CONTRACT DECLARATIONS AND EXECUTION

RFP #	Contract #
N/A	MED-17-007

Title of Contract
The Dental Wellness Plan for the Iowa Wellness

This Contract must be signed by all parties before the Contractor provides any Deliverables. The Agency is not obligated to make payment for any Deliverables provided by or on behalf of the Contractor before the Contract is signed by all parties. This Contract is entered into by the following parties:

Agency of the State (hereafter "Agency")	
Name/Principal Address of Agency: Iowa Department of Human Services 1305 E. Walnut Des Moines, IA 50319	**Agency Billing Contact Name / Address:** Sabrina Johnson Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315 **Phone:** 515-256-4650
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Sabrina Johnson Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Mikki Stier Iowa Medicaid Enterprise 100 Army Post Road Des Moines, IA 50315
E-Mail: sjohnso1@dhs.state.ia.us	**E-Mail:** mstier@dhs.state.ia.us
Phone: 515-256-4650	

Contractor: (hereafter "Plan" or "Contractor")	
Legal Name: MCNA Insurance Company	**Contractor's Principal Address:** 200 West Cypress Creek Road Suite 500 Fort Lauderdale, Florida 33309
Tax ID #: 420959302	**Organized under the laws of:** State of Iowa

Contractor's Contract Manager Name/Address ("Notice Address"): Mayre Thompson or Shannon Turner	**Contractor**'s **Billing Contact Name/Address:** Edward Strongin Chief Financial Officer 200 West Cypress Creek Road Suite 500 Fort Lauderdale, Florida 33309
Phone: 800-494-6262 Ext. 164 or Ext. 252	
E-Mail: mherring@mcna.net or sturner@mcna.net	

Contract Information	
Start Date: July 1, 2016	**End Date of Base Term of Contract:** June 30, 2017
Contract Payments include Federal Funds? Yes **The contractor for federal reporting purposes under this contract is a:** vendor **DUNS #:** 080277476 **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
Possible Extension(s): The Agency shall have the option to extend this Contract up to 1 additional 2-year extension.	
Contractor a Business Associate? Yes	**Contract Warranty Period (hereafter "Warranty Period"):** The term of this Contract, including any extensions.
Contract Include Sharing SSA Data? No	**Contract Payments include Federal Funds?** Yes **CFDA#:** #
Contractor subject to Iowa Code Chapter 8F? No	**Contract Contingent on Approval of Another Agency:** Yes **Which Agency?** CMS
Contractor a Qualified Service Organization? No	

Contract Execution

This Contract consists of this Contract Declarations and Execution Section, the attached General Terms for Services Contracts, Special Terms, and all Special Contract Attachments. In consideration of the mutual covenants in this Contract and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into this Contract and have caused their duly authorized representatives to execute this Contract.

Contractor, MCNA Insurance Company	**Agency, Iowa Department of Human Services**
Signature of Authorized Representative:	Signature of Authorized Representative:
Printed Name: Glen Feingold	Printed Name: Charles M. Palmer
Title: Executive Vice President and COO	Title: Director
Date:	Date:

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.

"Capitation payment" means a payment the Agency makes periodically to a contractor on behalf of each Enrollee enrolled under a contract for the provision of medical or dental services under the State plan. The Agency makes the payment regardless of whether the particular Enrollee receives services during the period covered by the payment.

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency in the U.S. Department of Health and Human Services responsible for administration of the Medicaid (Title XIX) program.

"Code of Federal Regulations (CFR)" means the publication of the Office of the Federal Register containing a codification of the general and permanent Rules published in the federal register of the Executive department and agencies of the Federal Government.

"Cold Call Marketing" means any unsolicited personal contact by the Plan with a potential Enrollee for the purpose of Marketing.

"Covered Services" means those Necessary Dental Services set forth under Section 1.3.1.4 of this Contract.

"Care Facilitation" means deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

"Day" means calendar day, except where the term working day is expressly used.

"Dental Wellness Plan" means the dental benefit plan available to Enrollees enrolled in the Iowa Wellness Plan.
"Emergency Dental Condition" means a dental condition of sudden onset and severity which would lead a prudent layperson to conclude that the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. The dental procedures will identify the source of the patient's significant pain, extent of trauma, source of infection, suspicious carcinoma, with palliative measures, or treat a traumatic clinical condition to the teeth and/or supporting structures.

The determination of whether an Emergency Dental Condition exists shall be decided by a dental professional and shall be based on the Enrollee's dental condition, including presenting symptoms and dental history prior to treatment. In cases where the above criteria are satisfied, any Prior Authorization procedures are precluded.

"Emergency Services" means those dental services rendered for an Emergency Dental Condition furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Dental Condition.

"Enrollee" means a Member who is currently enrolled in the Plan.

"Enrollment Area" means the county or counties in which the Plan is licensed to operate by the State of Iowa and in which service capability exists as determined solely by the Agency and set forth in this Contract. An Enrollment Area shall not be less than an entire county.

"Grievance Procedure" means a process by which an Enrollee may express dissatisfaction with services and benefits received under the Plan and for the resolution of actions.

"Iowa Wellness Plan" means the plan available to qualified individuals whose modified adjusted income is zero to 138 percent of the federal poverty level (FPL).
"Indian" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR § 136.12. This means the individual:

(i) Is a member of a Federally recognized Indian tribe;
(ii) Resides in an urban center and meets one or more of the four criteria:
(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;
(B) Is an Eskimo or Aleut or other Alaska Native;
(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(D) Is determined to be an Indian under regulations issued by the Secretary;
(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or
(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

"Indian health care provider" (IHCP*)* means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

"Indian managed care entity" (IMCE) means a MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

"Marketing" means any communication, from the Plan to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in the Plan's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's, PIHP's, PAHP or PCCM's Medicaid product.

"Marketing Materials" means materials: that are produced in any medium, by or on behalf of the Plan can reasonably be interpreted as intended to market to Potential Enrollees.

"MCO" means Managed Care Organization.

"Member" means an adult between the ages of 19-64 who are determined eligible for the Iowa Wellness Plan.

"Member Engagement" means involving the Enrollee to take an active role in their dental care.

"Necessary Dental Services" means a dental procedure or service as determined by the Plan, , to be required to preserve and maintain a Enrollee's oral health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Enrollee, as determined by acceptable standards of dental practice and not solely for the convenience of the Enrollee, Enrollee's Provider, or other health care provider.

"Non-participating Provider" means a provider who has not entered into a contract with the Plan to provide Covered Services to Enrollees.

"PAHP" means Prepaid Ambulatory Health Plan.

"PCCM" means Primary Care Case Manager.

"PIHP" means Prepaid Inpatient Health Plan.

"Prepaid Ambulatory Health Plan (PAHP)" means an entity that--

(1) Provides medical and dental services to Enrollees under contract with the Agency, and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State plan payment rates;

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and

(3) Does not have a Comprehensive Risk Contract.

For this Contract, the Dental Wellness Plan is a PAHP.

"Plan" means the health maintenance organization, organized delivery system, preferred provider organization, dental carrier, or the managed care organization with a certificate of authority to do business in Iowa, which is obligated under this Contract.

"Potential enrollee" means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO, PIHP , PAHP, or PCCM.

"Prior Authorization" means approval granted in advance of service for payment purposes by the Plan for its active Enrollees.

"Provider" means a dental care provider who has entered into a contract with the Plan to provide Covered Services to Enrollees.

"Quality Improvement" means the process of assuring that the delivery of dental care is continually assessed for quality by reviewing, at a minimum, the appropriateness, timeliness, accessibility and availability of care.

"Quarter" means three consecutive months of the State Fiscal Year. The first Quarter of the State Fiscal Year begins with July.

"Reporting Manual" means the document to be distributed by the Agency after Contract execution, detailing the reporting requirements for the program.

"Risk" means the possibility of monetary loss or gain by the Plan on service costs exceeding or being less than payments made to it by the Agency.

"Stabilization Services" means dental services to restore basic human functioning and prevent an existing clinical condition from further deterioration in an immediate time frame to a more serious and costly situation.

"State Fiscal Year" means the year period used by the state for accounting purposes that begins July 1, and ends June 30, of the following calendar year.

"U.S.C.A" means the United States Code Annotated, which is the codification by subject matter of the general and permanent laws of the United States.

1.2 Contract Purpose & Scope of Work

The parties are entering into the Contract to retain the Plan to provide dental benefits for the Iowa Wellness Plan. The goal of this dental benefits program is to focus on improving or restoring basic dental functionality for the

Enrollees; improving the oral health of Enrollees over time; habilitating Enrollees through education, care facilitation and community support; ensuring adequate, quality access to dental providers across the state; and establishing a meaningful and sustainable adults dental program for Iowa.

1.2.1 Dental Wellness Plan Program Description

The Dental Wellness Plan is a comprehensive dental benefits program for Iowa Wellness Plan. The Dental Wellness Plan is a new approach to dental care. Key features of this plan include:

- Adequate reimbursement rates for dental services, including performance incentives for Providers.
- A 'population health' approach to dental that will include Member Engagement, Enrollee education and outreach, and accountability for dental outcomes.
- Enrollee incentives by providing coverage for a basic array of services, with Enrollees earning the use of higher cost restorative services through demonstrated use of preventive services, compliance to treatment plans, and maintaining good oral health.

The Dental Wellness Plan shall demonstrate an innovative, high quality, cost effective and sustainable adult dental program that will provide a model that could be adopted for the rest of the Medicaid program.

1.2.1.1 Plan Design

1.2.1.1.1 Provider Network

The Plan shall develop a state-wide provider network and provide competitive reimbursement rates to its provider panel, that in aggregate, are similar to a commercial PPO rate.

1.2.1.1.2 Provider Incentive Program

The Plan shall develop a Provider Incentive Plan to Providers who meet specific quality measurements as outlined by the Plan. The proposed Incentive Plan shall be submitted to the Agency for review and approval. The Incentive Plan shall also address how the Plan will educate and engage dental providers in alignment with program goals.

Beginning July 1, 2016, funding of the Provider Incentive Plan (Provider Incentive Program) shall be a $2.07 PMPM included in the capitation rate(s). This funding shall be based on the number of members enrolled with the Plan (Enrollees) and is not subject to service volume.

For the year beginning July 1, 2016, the Plan shall develop a Provider Incentive Program that addresses the following quality measurements and objectives:

1. The Provider Incentive Program shall be used to incentivize annual completion of member oral health risk assessment.
2. The Provider Incentive Program shall be used to incentivize additional core diagnostic and preventative services.
3. The Provider Incentive Program and Plan fee schedules shall be structured to approximate PPO-like reimbursement rates for all dental providers.

The Plan's proposed Provider Incentive Program shall be provided to the Agency for review and approval no later than July 15 of each Contract year. The Agency shall provide approval of the proposed Provider Incentive Program within fifteen days of Plan response to all Agency concerns and recommendations regarding the proposed Provider Incentive Program. The Plan shall document that all funds provided to the Plan through the capitation rates for the Provider Incentive Program were spent on provider incentive program activities outlined in the approved Provider Incentive Program. This documentation shall be provided within 120 days of completion of the Contract year. To the extent any funds provided to the Plan through the capitation rates for the Provider Incentive Program are not used in accordance to the approved Provider Incentive Program, the excess funds shall be returned to the Agency within 120 days following the end of the Contract year. The Agency bears no responsibility for incentive payments to Plan

providers that exceed the amount of funds provided to the Plan through the capitation rates for the Provider Incentive Program.

1.2.1.1.3 Reduction of Administrative Burdens

The Plan shall reduce administrative burdens for Providers by ensuring that:

- Claims are paid timely;
- The billing system is easily utilized by Providers; and
- Provider satisfaction through the use of annual Provider survey.

1.2.1.1.4 Utilization of Knowledge.

The Plan's knowledge gained through the course of the Contract can be utilized during and, if applicable, after participation in the program ends.

1.2.1.1.5 Utilization of Data

During the term of this Contract, the Plan shall analyze Medicaid data for use of acute care system for dental issues and design and implement strategies for reducing use of acute care system. Once the contract ends, the Plan will no longer utilize the Agency's Enrollee data but may request from the Agency de-identified data for research or other purposes.

1.2.1.1.6 Care Facilitation

The Plan shall provide a Care Facilitation plan to the Agency for review and approval within thirty (30) days of the execution of the Contract. The Care Facilitation plan shall show how the Plan will create systems that provide for coordination of dental care and dentists with health homes, safety net providers, Accountable Care Organizations (ACOs) and Physicians to achieve program goals of the Iowa Health and Wellness Plan.

1.2.1.1.7 Enrollee Engagement, Education and Outreach

The Plan shall manage population health by focusing on restoring basic functionality for all Enrollees and improving the oral health of Enrollees over time through education, Enrollee engagement and community support by such means as, but not limited to:

- Increasing use of preventive services versus restorative services;
- Assessing oral health status and risk;
- Educating Enrollees on the covered services and Enrollee incentives based on healthy behaviors;
- Identifying Enrollees needing care through analysis of Medicaid claims data; and
- Utilizing community resources and health and dental Providers to educate Enrollees of the importance of oral health care and treatment.

The Plan shall provide an Enrollee outreach and communication plan, including Enrollee materials to the Agency for review and approval within ten (10) days of the execution of this Contract.
Also see Sections 1.3.1.4.3, 1.3.1.12, and 1.3.2 of this Contract. Information that includes the State's name and correspondence that may be sent to participants on behalf of the Agency shall also be submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in their marketing or other member communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in member communication materials.

Beginning with the State Fiscal Year 2017 Contract period, the Plan shall provide a revised, annual Enrollee outreach and communication strategy. The Plan shall submit the outreach and communication

strategy to the Agency for review and approval no later than 20 days prior to the beginning of each Contract year. Funding of the outreach and communication strategy shall be through a fixed amount included in the capitation rate(s). This funding shall be $0.59 PMPM included in the capitation rate and based on the number of members enrolled with the Plan (Enrollees) established by the Agency with Plan input. Also see Sections 1.3.1.4.3, 1.3.1.12, and 1.3.2 of this Contract.

The Plan shall document that all funds provided to the Plan for outreach and communication were spent on activities outlined in the approved outreach and communication strategy. This documentation shall be provided within 120 days of completion of the Contract year. To the extent any funds provided to the Plan for outreach and communication are not used in accordance to the approved outreach and communication strategy, the excess funds shall be returned to the Agency within 120 days following the end of the Contract year. The Agency bears no responsibility for outreach and communication expenditures that exceed the amount of funds provided to the Plan for this purpose.

The Agency will track and report to the Plan hospital emergency room utilization for non-emergent dental care. The Plan shall develop referral protocols with local emergency room departments for non-emergent dental care. The Plan shall also monitor ER utilization for all Dental Wellness Plan members and follow up with Enrollees.

1.2.1.1.8 Benefits

The Plan shall provide comprehensive dental services, through an earned benefit, up to benefits equivalent to the current Medicaid dental program. The Dental Wellness Plan shall cover basic dental care and treatment to all Iowa Wellness Plan Members. Enrollees would be able to earn coverage for more expensive restorative services by completing preventive screenings and recommended treatment plans. See Attachment 3.1 for list of services and benefits.

The Plan shall provide a plan within 60 days of contract initiation for review and approval by the Agency for how the Plan will track and report to the agency the Enrollee's activities relative to the earned benefit when the Enrollee becomes disenrolled and then reenrolls within a specified time period to assure continuity of benefits when there is a break in enrollment. Enrollee's tier level will be reported to the Agency as prescribed in the Reporting Manual.

1.2.1.2 General

Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered to Enrollees. The Agency will use various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and outcomes. The Agency reserves the right to publish Contractor performance.

1.2.1.3 Reporting

The Contractor shall comply with all reporting requirements and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate. In accordance with 42 C.F.R. § 438.604 and 42 C.F.R. § 438.606, Contractor shall certify enrollment information, encounter data, and other information submitted to the Agency for purposes of developing managed care rates. All such certified data shall be certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees. The certification shall attest, based on best knowledge, information and belief the accuracy, completeness and

truthfulness of the data and documents submitted to the Agency. This certification shall be submitted concurrently with the certified data.

1.2.1.4 Meeting with the Agency

The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data.

1.2.1.5 Implementation Reporting

The Agency reserves the right to require more frequent reporting at the beginning of the Contract to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of Enrollees and provider services.

1.2.1.6 Other Reporting and Changes

The Agency may change the frequency of reports and may require additional reports and performance targets at any time. In these situations, the Agency will provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. The Agency may request ad hoc reports at any time. The Reporting Manual, which shall be provided following the Contract effective date, will detail reporting requirements and the full list of required reports.

1.2.1.7 Tracking and Reporting

The Contractor shall institute a system that integrates information about Enrollees in order to facilitate positive Enrollee outcomes through education and outreach. The system shall have the ability to track the results of the initial oral health screening, comprehensive oral health risk assessment, Enrollee outcomes and have the ability to share information with the Enrollee, his or her authorized representatives, and all relevant treatment providers, including, but not limited to primary care providers and specialists. The Contractor shall submit regular reporting regarding the selection criteria, strategies & outcomes of education and outreach programs as prescribed in the Reporting Manual.

1.3 General Obligations -- Scope of Work.

1.3.1 Deliverables.

In performing services pursuant to this Contract, the Plan shall comply with the following general obligations:

1.3.1.1 Statutory Requirements

- The Plan shall retain at all times during the period of this Contract a valid Certificate of Authority issued by the State of Iowa Office of the Commissioner of Insurance.
- Disclosure of Financial Records

  The Plan shall make available to the Agency, the Agency's authorized agents and appropriate representatives of the U.S. Department of Health and Human Services, any financial records of the Plan, which relate to the Plan's capacity to bear the Risk of potential financial losses and records of the Covered Services performed and amounts paid or payable under this Contract. The Plan shall comply with applicable record keeping requirements as specified in Section 2.13.25. Records Retention and Access of this Contract.

1.3.1.2 Enrollment in the Dental Wellness Plan

1.3.1.2.1 Enrollment Area

The Enrollment Area for which the Plan agrees to provide services shall be the State of Iowa for which a valid certificate of authority has been issued by the Insurance Division of the Department of Commerce and for which the Agency has determined there is a sufficient panel of contracted Providers able to meet the needs of Enrollees.

1.3.1.2.2 Eligibility Determinations

The Agency shall determine eligibility of adults to participate in the Iowa Wellness Plan and shall notify the Plan of enrollment in the Dental Wellness Plan.

1.3.1.2.3 Establishment of Effective Date of Coverage

The Agency shall establish the effective date of coverage for the Enrollee. The effective date of coverage shall be the first day of the month following the eligibility determination by the Agency.

1.3.1.2.4 Choice of a Plan

Upon initial enrollment in the Iowa Health and Wellness Plan, Enrollees shall have the right to choose a Plan where a choice is available.

1.3.1.2.5 Plan Information

The Agency shall provide the Enrollee with information about all Plans available to the Enrollee. Such information shall be provided to the Agency by the Plan. When requested, the Agency shall assist the Enrollee in the selection of a Plan when more than one plan is available. Such assistance shall be provided in an unbiased manner.

1.3.1.2.6 12-Month Enrollment Period

Unless this Contract is terminated earlier, upon selection of a Plan, the Enrollee shall remain enrolled in the selected Plan for a period of twelve (12) months as long as the Enrollee remains eligible for the Iowa Wellness Plan program, but subject to the following conditions:

1. Enrollee shall have the right to terminate enrollment for cause in accordance with 42 U.S.C.A §1396u-2(a)(4)(A)(i) ; and
2. Enrollee shall have the right to terminate without cause during the 90-Day period beginning on the date the individual receives notice of such enrollment, and at least every 12 months thereafter in accordance with 42 U.S.C.A. §1396u-2(a)(4)(A)(ii).

1.3.1.2.7 Enrollment File to the Plan

The Agency shall transmit an enrollment file to the Plan in a format as agreed upon by all parties as follows:

1. A daily enrollment file that:
   - Lists all new or renewed Dental Wellness Plan Enrollees for each month of coverage.
   - Lists Dental Wellness Plan Enrollees that have (i.e., name change, address change, etc.)
2. A monthly file that lists all Dental Wellness Plan Enrollees eligible for the programs for that month.

The Plan shall accept as Enrollees all persons who appear on the Plan enrollment file without restriction.

1.3.1.2.8 Open Enrollment

The Plan shall maintain a continuous open enrollment period during which the Plan shall accept Enrollees eligible for coverage under this Contract.

1.3.1.2.9 Receipt of Enrollment Files

The Plan shall download both the daily and the monthly enrollment files on a daily basis in the same order as transmitted by the Agency.

1.3.1.2.10 Periodic Reviews of Eligibility

The Agency shall periodically conduct a review of the Enrollee's circumstances to establish the Enrollees's continued eligibility to participate in the Iowa Wellness Plan.

Sixty (60) Days prior to the annual review of eligibility, the Enrollee may notify the Agency that they wish to disenroll from the Plan and choose another Plan, if available, effective the first day of the next twelve (12)-month enrollment cycle. Failure to notify the Agency of an intent to change Plans during this

period shall result in the Member being enrolled for an additional twelve (12) months with the same Plan upon the determination that the Member continues to qualify for participation in the Iowa Wellness Plan program.

1.3.1.2.11 Request for Enrollment Information

Upon request, the Plan shall have the right to examine and inspect all information in the possession of the Agency regarding the enrollment process and the number of Members enrolled.

1.3.1.3 Disenrollment

The Agency shall make all decisions regarding the disenrollment of a Enrollee from the Plan and notify the Plan of the disenrollment in accordance with this Section.

Any Enrollee who is disenrolled from a Plan shall be automatically re-enrolled with the same Plan upon reinstatement of eligibility if reinstatement occurs within the Member's same twelve (12)-month enrollment cycle.

1.3.1.4 Covered Services

The Plan shall provide coverage of all services required in Section 1.3.1.4.2 of this Contract. The Agency shall provide the Plan with ninety (90) Days' advanced written notice preceding any change in Covered Services under this Contact unless such change is pursuant to a legislative, or regulatory mandate, in which event, the Agency shall use best efforts to provide reasonable notice to the Plan. In the event the Agency provides less than ninety (90) Days' advanced written notice to the Contractor, the Contractor shall comply with the change in Covered Services within ninety (90) Days from the date the notice is given.

The Plan shall not avoid costs for services covered in this Contract by referring Enrollees to publicly supported dental care resources in accordance with 42 CFR 457.950(a)(4).

1.3.1.4.1 Effective Date of Coverage for Enrollee

The Plan shall assume responsibility for all Covered Services for each Enrollee as of the effective date of coverage as determined by the Agency and provided on enrollment files to the Plan. The effective date of coverage may be retroactive from the date the enrollment file is sent to the Plan.

1.3.1.4.2 Required Covered Services

The Plan shall cover all Services in Attachment 3.1 (including Emergency Dental Services) when services are Necessary Dental Services. Services must be sufficient in amount, or scope to achieve the purpose of this Contract. Services may not arbitrarily be denied or reduced in the amount, duration, or scope of a required service solely because of the dental condition.

The Plan may place appropriate limits on a service on the basis of criteria, such as dental necessity; for utilization control, provided the services furnished can reasonably be expected to achieve their purposes.

The Plan shall provide all Enrollees from the Enrollee's 19th birthday through the day before the person's 21st birthday with the Enhanced Plus benefit set forth in Attachment 3.1. See Attachment 3.1 for list of core benefits, enhanced benefits and enhanced plus benefits.

Moral or religious objections. An MCO, PIHP, or PAHP that would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service is not required to do so if the MCO, PIHP, or PAHP objects to the service on moral or religious grounds.

Information Requirements. If the Plan elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

- to the State;
- with its application for a Medicaid contract;

- whenever it adopts the policy during the term of the contract; and
  - it must be consistent with the provisions of 42 CFR 438.10
  - it must be provided to potential enrollees before and during enrollment
  - it must be provided to enrollees within 90 days after adopting the policy with respect to any particular service.

1.3.1.4.3 Enrollee Engagement

The Plan shall ensure the provision of Enrollee engagement by utilizing partners to work with providers and Enrollees to promote successful compliance with treatment plans and use of preventive care. This will include educating Enrollees about good oral hygiene, prevention and maintenance of teeth and gums. The Plan shall work with key community service organizations including the Department of Public Health, to provide resources for community partners so they can assist in education and awareness activities at the local level and support Enrollee education and compliance, including linking Enrollees with participating dental providers.

The Plan shall establish a process for ongoing care facilitation and coordination with the Enrollee's physical health care to ensure Member-centeredness.

1.3.1.4.4 Pre-existing Conditions

The Plan shall not deny reimbursement of Covered Services based on the presence of a pre-existing dental condition.

1.3.1.4.5 Information to Enrollees and Potential Enrollees

The Plan shall, upon request, make available to Enrollees and potential Enrollees in the Plan's service area information concerning the following:

i. *Providers.* The identity, location, qualifications, and availability of dental care providers that participate with the Plan.
ii. *Enrollee Rights and Responsibilities*. The rights and responsibilities of Enrollees.
iii. *Grievance and appeal procedures*. The procedures available to an Enrollee and a dental care provider to challenge or appeal the failure of the Plan to cover a service.
iv. *Information on covered items and services*. All items and services that are available to Enrollees under the Contract between the Agency and the Plan that are covered either directly or through a method of referral and Prior Authorization.

The information required to be provided pursuant to this Section includes but is not limited to that listed in Section 1.3.1.5. The Plan shall provide all enrollment notices, informational materials, and instructional materials relating to Enrollees and potential Enrollees in a manner and format that may be easily understood at a sixth grade level. Information that includes the State's name and correspondence that may be sent to participants on behalf of the Agency shall also be submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in their marketing or other member communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in member communication materials.

1.3.1.4.6 Second Opinion

At the request of an Enrollee, the Plan must provide for a second opinion from a qualified dental care professional within the network, or arrange for the ability of the Enrollee to obtain one outside the network, at no cost to the Enrollee.

1.3.1.4.7 Choice of Oral Health Professional

The Plan must allow each enrollee to choose his or her oral health professional to the extent possible and appropriate.

1.3.1.4.8 Assessment for Special Health Care Needs.

The Plan must implement mechanisms to assess each Medicaid Enrollee identified by the Agency and identified to the Plan by the Agency as having special health care needs in order to identify any ongoing special conditions of the Enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate Health Care Professionals.

1.3.1.4.9 Enrollees with Special Health Care Needs

The Plan must use diligent efforts to identify Enrollees with special health care needs. This can be performed through an assessment of the Enrollee's health status upon enrollment or though identification by PCPs. When found, the Plan must develop a treatment plan, if the Agency requires the Plan to develop such a plan, in conjunction with the PCP to determine the necessity of additional care management to meet the needs of the Enrollee. If it is determined that services of a Specialist physician are necessary to perform Care Facilitation, the Plan shall allow direct access to such a Provider without referral or through a mechanism of a standing referral or defined number of visits.

1.3.1.4.10 Direct Access to Specialists

The Plan must allow direct access to Specialists for those Enrollees determined to need a course of treatment or regular care monitoring as may be appropriate for the Enrollee's condition, earned benefit level, and identified needs.

1.3.1.5 Enrollee Information

1.3.1.5.1 Plan Information for Enrollees

The Plan shall mail the Enrollee identification cards within ten (10) working days and all other materials to Enrollees within twenty (20) working days of Plan's notification by the Agency that the Enrollee is eligible. At a minimum, the materials shall include:

- The phone number(s) that can be used for assistance to obtain information about emergency care, Prior Authorization, scheduling appointments, and standard benefit/service information;
- Current provider directory, which must include the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Enrollee's service area, including identification of providers that are not accepting new patients. This includes information on specialists. Provider directory will be available on Plan website unless Enrollee specifically requests a written copy. Instructions for how to locate a Provider will be included in other mailed materials to the provider;
- Hours of service of the Plan;
- Any restrictions on the Enrollee's freedom of choice among network Providers;
- Grievance and appeal procedures, including the information required by 42 C.F.R. § 438.10(h);
- Policies on the use of emergency services;
- Limited Plan liability for services from Non-Participating Providers;
- Information on emergency care coverage, including the fact that Prior Authorization is not required for emergency services;
- Enrollee rights and responsibilities, as specified in 42 C.F.R. § 438.100;
- Accessing out of area services;
- Procedures for notifying Enrollees affected by changes in Covered Services or their Delivery;
- Procedures for recommending changes in policies and services;
- The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled; and
- Information on how and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost sharing. The Plan shall provide copies of the

Enrollee information to the Agency by January 15th of each Contract year. In addition, should the Plan adopt a policy in relation to any particular service, the Plan shall provide the information to current Enrollees within 30 Days and to all potential Enrollees on a going forward basis.

1.3.1.5.2 Enrollee Rights

The Plan shall have written policies outlining Enrollee rights, including but not limited to the rights identified below. These policies shall be communicated to Enrollees and shall be available to the Agency and Providers.

A. Receive Information. The Enrollee shall receive information in accordance with Section 1.3.1.5.1.

B. Respect. The Enrollee shall be treated with respect and with due consideration for his or her dignity and privacy.

C. Non-English Speaking Enrollees. The Plan shall assure that services are accessible to all Enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities. As appropriate, printed materials provided to Enrollees shall be written in no higher than a sixth grade reading level.

The Agency shall notify the Plan in writing if ten (10) percent or more of the Plan's Dental Wellness Plan Enrollees speak the same non-English language. Upon notification, the Plan shall provide the identified Enrollees information written in the applicable language regarding access of Covered Services and the mechanism to obtain further information about the Plan in the Enrollee's native language.

Upon notification from the Agency, the Plan shall ensure that non-English speaking Enrollees are provided information on the benefits and restrictions associated with enrollment in the Plan in the non-English language. At the time of this contract, the Agency is requiring materials be available in Spanish.

The Plan shall make oral interpretation services available and to make those services available free to charge to each Potential Enrollee and Enrollee. This applies to all non-English languages, not just those that the Agency identifies.

D. Visually Impaired Enrollees. For Enrollees identified as visually impaired, the Plan shall provide basic Plan information in large print and Braille formats or through other means, including information regarding how to access services.

E. Privacy and Confidentiality of Dental Records.
The Plan shall assure confidentiality of Enrollee's dental, health and medical records and other information in the Plan's possession consistent with state and federal laws. The Enrollee shall be guaranteed the right to request and receive a copy of his or her medical or dental records, and to request that they may be amended or corrected as specified in 45 CFR part 164.

F. Disclosure of Treatment Options
   a. The Plan shall not prohibit, or otherwise restrict, a dental health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient:

      - For the enrollee's health status, dental care, or treatment options, including any alternative treatment that may be self-administered.
      - For any information the enrollee needs in order to decide among all relevant treatment options.
      - fFr the risks, benefits, and consequences of treatment or non-treatment.
      - For the enrollee's right to participate in decisions regarding his or her oral health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

b. *In General.* Subject to subparagraphs (b) of this subsection, the Plan (in relation to an individual enrolled under the Contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (c)) from advising such an individual who is a patient of the professional about the dental status of the individual or dental care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the Contract, if the professional is acting with the lawful scope of practice.

c. ***"****Dental care professional" defined.* For purposes of this Section 1.3.1.5.2, and all subparagraphs thereof, the term "health care professional" means a dentist (see 42 U.S.C.A. § 1395x(r)(2)) or other health care professional if coverage for the professional's services is provided under the Contract for services of the professional.

G. Participation in Dental Care Decision Making. The Plan shall provide for Enrollee's participation in his or her treatment planning when appropriate.

H. Discrimination. The Plan shall not discriminate against individuals eligible to enroll on the basis of:
- Health status or need for dental care services, discriminate against individuals eligible to enroll.
- Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

I. Free exercise of rights. Each Enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Plan and its Providers or the Agency treat the Enrollee.

1.3.1.6 Provider Network and Access to Services

1.3.1.6.1 Provider Network

The Plan shall provide Covered Services through its contracted Provider panel. The Plan shall notify the Agency in writing if there is a substantial change in the provider panel. The Agency reserves the right to terminate the Contract in the Enrollment Area where there has been a substantial change in the provider panel as described in this Contract.

The Plan shall meet and require its provider panel to meet Agency standards for timely access to care and services, taking into account the urgency of need for services. The Plan shall require that its network Providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the Provider serves only Medicaid members.

The Plan must monitor timely access. The Plan shall:
- Establish mechanisms to ensure that network Providers comply with the timely access requirements;
- Monitor regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

Nature of supporting documentation. The Plan must submit documentation to the Agency, in a format specified by the Agency to demonstrate that it complies with the following requirements:
- Offers an appropriate range of preventive and specialty services that are adequate for the anticipated number of Enrollees for the service area.
- Maintains a network of Providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees in the service area.

The Plan must submit documentation assuring adequate capacity and services as specified by the Agency, and specifically as follows, but no less frequently than:
- At the time it enters a contract with the Agency; and

- At any time there has been a significant change in the Plan's operation that would affect adequate capacity and services including:
    - Changes in services, benefits, geographic service area or payment, or
    - Enrollment of a new population in the Plan.

1.3.1.6.2 Accessible Services

The Plan shall make reasonable efforts to pursue contracts with dental health practitioners providing services to Enrollees that are sufficient in terms of geographic convenience to low-income areas, disabled accessibility and proximity to public transportation routes.

Delivery network. The Plan shall assure that Enrollees have adequate access to dentists. The Plan shall meet the following requirements:

(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the Plan must consider the following:

(i) The anticipated Medicaid enrollment.

(ii) The expected utilization of services, taking into consideration the characteristics and oral health care needs of specific Medicaid populations represented in the Plan.

(iii) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.

(iv) The numbers of network providers who are not accepting new Medicaid patients.

(v) The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.

1.3.1.6.3 Indian Healthcare Providers

1.3.1.6.3.1 Network and coverage requirements.

(1) The Plan shall demonstrate that there are sufficient IHCPs participating in the provider network of the Plan to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services.

(2) The Plan shall pay IHCPs, whether participating or not, for covered services provided to Indian enrollees who are eligible to receive services from such providers as follows:

(i) At a rate negotiated between the Plan and the IHCP, or

(ii) In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the Plan would make for the services to a participating provider which is not an IHCP; and

(iii) Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 C.F.R. § 447.45 and § 447.46.

(3) The Plan shall permit any Indian who is enrolled in the Plan that is not an IMCE and eligible to receive services from a IHCP primary care provider participating as a network provider, to choose that IHCP as his or her primary care provider, as long as that provider has capacity to provide the services.

(4) The Plan shall permit Indian enrollees to obtain services covered under the Contract from out-of-network IHCPs from whom the enrollee is otherwise eligible to receive such services.

(5) If timely access to covered services cannot be ensured due to few or no IHCPs, the Plan shall be considered to have met the requirement in paragraph 1.3.1.6.3.1(1) of this section if--

(i) Indian enrollees are permitted by the Plan to access out of-State IHCPs; or

(ii) If this circumstance is deemed to be good cause for disenrollment from both the Plan and the State's managed care program in accordance with § 438.56(c).

(6) The Plan shall permit an out-of-network IHCP to refer an Indian enrollee to a network provider.

1.3.1.6.3.2 Payment requirements.
(1) When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the Plan, the Plan shall pay the IHCP at an amount equal to the amount the Plan would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the State to make up the difference between the amount the Plan pays and what the IHCP FQHC would have received under FFS.
(2) When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Plan or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology. In such case, the Plan shall pay the IHCP the rate the IHCP is entitled to.
(3) When the amount a IHCP receives from the Plan is less than the amount required by paragraph 1.3.1.6.3.2(2) of this section, the State must make a supplemental payment to the IHCP to make up the difference between the amount the Plan pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

1.3.1.6.3.3 Enrollment in IMCEs. An IMCE may restrict its enrollment to Indians in the same manner as Indian Health Programs, as defined in 25 U.S.C. § 1603(12), may restrict the delivery of services to Indians, without being in violation of the requirements in 42 C.F.R. § 438.3(d).

1.3.1.6.4 Emergency Services
The Plan shall provide benefits for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Plan. The Plan may not deny payment for treatment obtained when a representative of the Plan instructs the Enrollee to seek emergency services. The Plan shall not require Prior Authorization preceding treatment of an Emergency Dental Condition. The Plan may not deny payment for treatment obtained when an enrollee had an Emergency Dental Condition, including cases in which the absence of immediate dental attention would not have had the outcomes, as they relate to dental services, specified in 42 CFR 438.114(a).

1) The Plan shall cover and pay for Emergency Services regardless of whether the Provider that furnishes the services has a contract with the Plan.
    a) The Agency encourages the Plan and Providers to reach agreement on payment for services.
    b) The Plan shall pay Non-Participating Providers for Emergency Services at the current Dental Wellness Plan program rates in effect at the time of service unless the Plan and the Non-Participating Provider have negotiated a mutually acceptable rate. In conformity with the Deficit Reduction Act of 2005, Pub. L. No. 109-171 § 6085, 120 Stat. 121 (2006), any Provider of Emergency Services that does not have in effect a contract with a Medicaid Managed Care Entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under Title XIX other than through enrollment in such an entity.
2) The Plan may not deny payment for treatment obtained under either of the following circumstances:
    a) An Enrollee had an Emergency Dental Condition, which without immediate dental attention would result in an outcome as specified in the definition of Emergency Dental Condition specified herein.

b) A representative of the Plan instructs the Enrollee to seek Emergency Services.

3) An Enrollee who has an Emergency Dental Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

1.3.1.6.5 Provider Performance Appraisal and Credentialing

The Plan shall manage a credentialing, re-credentialing, recertification, and performance appraisal process for contracted Providers, which shall take into consideration, but not be limited to, the following: Enrollee complaints, quality reviews, utilization management information, and Enrollee satisfaction surveys. The Plan agrees to verify qualifications of Providers in accordance with State licensing standards or accrediting standards to assure quality of services and to provide information to the Agency upon request.

The Plan shall submit a description of the process and criteria utilized to the Agency within thirty (30) Days from the execution of this Contract.

The Plan shall not make payments to a Provider for any item or service furnished, ordered, or prescribed if the Provider is excluded from participating in the Medicare and Medicaid programs. The Plan shall notify the Agency of any network Providers who have been excluded from participating in Medicare and Medicaid and the date the Plan terminates the contract with the Provider. The Plan may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

The Plan shall have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the State's policy for credentialing and recredentialing. The Plan shall demonstrate that its providers are credentialed.

1.3.1.6.5.1 Provider Discrimination

The Plan shall not discriminate against any Provider acting within the scope of that Provider's license or certification with respect to participation, reimbursement, or indemnification solely on the basis of the Provider's license or certification. This provision shall not be construed as imposing on the "any willing Provider" requirement. The Plan may limit Provider participation to meet the needs of the Enrollees. The Plan may establish measures that are designed to maintain quality and control costs.

The Plan's provider selection policies and procedures cannot discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

If the Plan declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision. 42CFR 438.12 (a) may not be construed to:

- Require the Plan to contract with Providers beyond the number necessary to meet the needs of its Enrollee;
- Preclude the Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- Preclude the Plan from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Enrollee.

1.3.1.6.5.2 Notice of Provider Termination

The Plan shall make a good faith effort to give written notice of termination of a contracted Provider, within fifteen (15) days after receipt or issuance of a termination notice, to each Enrollee who received care on a regular basis, by the terminated Provider.

1.3.1.6.5.3 Federally Qualified Health Centers and Rural Health Clinics

The Contractor shall offer to contract with all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) located in Iowa. The Contractor may establish quality standards that FQHCs and RHCs shall meet to be offered network participation, subject to Agency review and approval. The Contractor shall reimburse all FQHCs and RHCs the Prospective Payment System (PPS) rate in effect on the date of service for each encounter. The Contractor shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from the State.

1.3.1.6.6 Out of Network Providers

If the Plan's network is unable to provide necessary dental service covered under this Contract to an Enrollee, the Plan must adequately and timely cover these services out of network, for as long as the Plan is unable to provide. Out of network Providers must coordinate with the Plan with respect to payment.

1.3.1.6.7 Authorization of Services

The Plan shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorization of services. The Plan shall have in place methods to ensure consistent application of review criteria for authorization decisions and consult with the requesting Provider when appropriate. The Plan must require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

The Plan shall not provide compensation to individuals or entities that conduct utilization management activities as to provide incentives for the individual or entity to deny, limit or discontinue Necessary Dental Services to any Enrollee.

1.3.1.6.8 Clinical Laboratory Improvement Act :(CLIA).

All laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

1.3.1.6.9 Subcontractual Relationships and Delegation

The Plan shall oversee and shall be held accountable for any functions and responsibilities that it delegates to any subcontractor (excluding Providers), including:

- All subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
- The Plan must evaluate the prospective subcontractor's ability to perform the activities to be delegated.
- The Plan shall have a written agreement between the Plan and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- The Plan shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State insurance laws and regulations.
- The Plan shall identify deficiencies or areas for improvement, for which the Plan and the subcontractor must take corrective action.

1.3.1.6.10 Provider identifier.

The Plan shall require each dental professional to have a unique identifier.

1.3.1.6.11 Dental Record Content.

The Plan shall assure that dental records are compliant with the utilization control requirements of 42 C.F.R. Part 456.

1.3.1.7 Claims Processing

1.3.1.7.1 Coordination of Benefits

The Plan shall ensure that benefits provided under the Dental Wellness Plan are coordinated with any other coverage the Enrollee may have available to pay for Covered Services. In the event a Dental Wellness Plan eligible Enrollee is retroactively enrolled in another Medicaid coverage group, the Dental Wellness Plan shall be the primary payor for the time period during which both coverages are effective. In the event a Dental Wellness Plan Enrollee is enrolled with other health or dental insurance coverage, the other insurance plan shall be the primary payor and the Dental Wellness Plan shall be the payor of last resort.

Primary care and coordination of health care services.

The Plan shall implement procedures to:

- Ensure that each enrollee has an ongoing source of coordination with member's primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
- Coordinate the services the Plan furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.
- Share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated.

To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164

1.3.1.7.2 Prohibited Enrollee Billing

The Plan shall not hold any Enrollee liable:

a. For the debts of the Plan, in the event of the Plan's insolvency,
b. For services provided to the individual –
    i. in the event of the Plan failing to receive payment from the Agency for such services; or
    ii. in the event of a health care provider with a contractual, referral, or other arrangement with the Plan failing to receive payment from the Agency or the Plan for such services, or
c. For payments to a provider that furnishes Covered Services under a contractual, referral, or other arrangement with the Plan in excess of the amount that would be owed by the individual if the organization had directly provided the services; or
d. For Covered Services not yet earned by the member as described in Attachment 3.1.

The Plan must cover continuation of services to enrollees for the duration of the period for which payment has been made, as well as for inpatient admissions up until discharge.

1.3.1.7.3 Copayments and Cost Sharing

The Plan shall not impose copayments or other cost sharing unless directed by the Agency.

1.3.1.7.4 Claim Filing Time Limits

The Plan may set reasonable notification and claim filing time limits for Non-Participating Providers. However, these limits shall not invalidate a claim if the Non-Participating Provider demonstrates that the

claim could not have been reasonably filed within the limit or that the Non-Participating Provider was attempting to collect from a liable third-party payer.

1.3.1.7.5 Third Party Liability

Third Party Liability is defined as any individual, entity, or program that is or may be liable to pay all or part of the health care expenses of a Medicaid beneficiary. Under Section 1902(a) (25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat Third Party Liability as a resource of the Medicaid beneficiary. The Plan may retain its third party collections. The capitated rates have been adjusted down by the amount of the Plan's expected collections.

1.3.1.7.6 Protection Against Liability – Subcontractors and Referrals

The Plan's subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the Plan provided the services directly (i.e., no balance billing by providers).

1.3.1.7.7 Provider Incentive Program (PIP)

a. Physician Incentive Plans. The Plan shall comply with the requirements set forth in 422.208 and 422.210, if applicable.
b. Prohibition – The Plan may operate a PIP only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual.
c. Disclosure to State. The Plan shall disclose to the State the following:
    - The Plan must report whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if PIP does not cover services not furnished by physician/group.
    - The Plan must report type of incentive arrangement, e.g. withhold, bonus, capitation.
    - The Plan must report percent of withhold or bonus (if applicable).
    - The Plan must report panel size, and if patients are pooled, the approved method used.
    - If the physician/group is at substantial financial risk, the Plan must report proof the physician/group has adequate stop loss coverage, including amount and type of stop-loss.
d. Substantial Financial Risk - if the physician/group is put at substantial financial risk for services not provided by the physician/group, the Plan must ensure adequate stop-loss protection to individual physicians and conduct annual enrollee surveys.
e. Disclosure to Beneficiaries - The Plan must provide information on its PIP to any Medicaid beneficiary upon request (this includes the right to adequate).
f. Disclosure to State - Survey - if required to conduct beneficiary survey, survey results must be disclosed to the State and, upon request, disclosed to beneficiaries.

1.3.1.8 Enrollee Grievance System

The Plan shall have a system in place for Enrollees and Providers acting upon their behalf, which includes a Grievance process, an Appeal Process, and access to the Agency's fair hearing system. The Plan shall provide the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

- the Enrollee's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;
- the Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
- the availability of assistance in filing;
- the toll-free numbers to file oral grievances and appeals;
- the Enrollee's right to request continuation of benefits during an appeal or State Fair Hearing filing and, if the Plan's action is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits; and
- any State-determined provider appeal rights to challenge the failure of the organization to cover a service.

The Plan must inform the enrollee of the limited time available for the enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited appeal resolution.

1.3.1.8.1 Definitions

For purposes of the Plan's Grievance/Appeal Process, the following definitions and requirements shall apply:

Action - can mean any of the following:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the Agency;
- Failure of an Plan to act within the timeframes; or
- For a rural area resident with only one Plan, the denial of a Medicaid Enrollee's request to obtain services outside the network:
    - from any other Provider (in terms of training, experience, and specialization) not available within the network;
    - from a Provider not part of the network who is the main source of a service to the recipient - provided that the Provider is given the same opportunity to become a participating Provider as other similar Providers. If the Provider does not choose to join the network or does not meet the qualifications, the Recipient is given a choice of participating Providers and is transitioned to a participating Provider within 60 Days;
    - because the only Plan or Provider available does not provide the service because of moral or religious objections;
    - because the recipient's Provider determines that the Recipient needs related services that would subject the Recipient to unnecessary risk if received separately and not all related services are available within the network; or
    - because the Agency determines that other circumstances warrant Non-Participating treatment.

Appeal – A request for review of an Action, as Action is defined in this section.

Appeal Process - The Plan's process for handling of Appeals that complies with the requirements specified herein, including, but not limited to, the procedural steps for an Enrollee to file an Appeal, the process for resolution of an Appeal, the right to access the Fair hearing system, and the timing and manner of required notifications.

Grievance -- An expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the Quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Enrollee's rights.

Grievance Process -- The Plan's process for handling of Grievances that complies with the requirements specified herein, including, but not limited to, the procedural steps for an Enrollee to file a Grievance, the process for disposition of a Grievance, and the timing and manner of required notifications.

Grievance System – The overall system in place for Enrollees that includes a Grievance process, an Appeal Process, and access to the Fair hearing system.

Inquiry - A request from an Enrollee for information that would clarify Plan policy, benefits, procedures, or any aspect of Plan function but does not express dissatisfaction.

Service Authorization -- A managed care Enrollee's request for the provision of a service.

1.3.1.8.2 Service Authorization and Notice of Action

1.3.1.8.2.1 Denial Procedure Requirement

Any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, based on the lack of Necessary Dental Services, must be made by a Dental Care Professional who has appropriate clinical expertise in treating the Enrollee's condition or disease.

1.3.1.8.2.2 Provider Notice of Adverse Action

The Plan must notify the requesting Provider of any decision to deny a Service Authorization request, or to authorize a service in an amount, duration or scope that is less than requested. This notice to the Provider does not need to be in writing.

1.3.1.8.2.3 Enrollee Notice of Adverse Action

The Plan must notify the Enrollee in writing of any decision to deny a Service Authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The Plan must give the Enrollee written notice of any Action (not just Service Authorization Actions) within the timeframes for each type of Action.

Content - The notice must explain:

- The Action the Plan or its Subcontractor has taken or intends to take;
- The reasons for the Action;
- The Enrollee's or the Provider's right to file an Appeal;
- The Enrollee's right to request a Fair hearing;
- Procedures for exercising Enrollee's rights to Appeal or grieve;
- Circumstances under which expedited resolution is available and how to request it; and
- The Enrollee's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay the costs of these services.

Language and format - The notice must be in writing and must meet the language and format requirements of §438.10(c) and (d) to ensure ease of understanding.

1.3.1.8.3 Timeframes for Notice of Action

1.3.1.8.3.1 Termination, suspension or reduction of services

The Plan must give notice at least 10 days before the date of Action when the Action is a termination, suspension, or reduction of previously authorized Covered Services, except:

- the period of advanced notice is shortened to 5 days if probable recipient fraud has been verified;
- by the date of the Action for the following:
    - in the death of a recipient;
    - a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
    - the recipient's admission to an institution where he is ineligible for further services;
    - the recipient's address is unknown and mail directed to him has no forwarding address;
    - the recipient has been accepted for Medicaid services by another local jurisdiction;
    - the recipient's physician prescribes the change in the level of medical care;
    - an adverse determination made with regard to the preadmission screening requirements;
    - or Nursing Facility admissions on or after January 1, 1989; or
    - the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 Days (applies only to adverse Actions for Nursing Facility transfers).

1.3.1.8.3.2 Denial of Payment

The Plan must give notice on the date of Action when the Action is a denial of payment.

1.3.1.8.3.3 Standard Service Authorization Denial

The Plan must give notice as expeditiously as the Enrollee's health condition requires and within Agency-established timeframes that may not exceed 14 calendar Days following receipt of the request for service, with a possible extension of up to 14 additional calendar Days, if the Enrollee, or the Provider, requests extension; or the Plan justifies a need for additional information and how the extension is in the Enrollee's interest (upon Agency request).

If the Plan extends the timeframe, the Plan must give the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

1.3.1.8.3.4 Expedited Service Authorization Denial

For cases in which a Provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires to the Provider and recipient as may be required and no later than 3 working Days after receipt of the request for service.

1.3.1.8.3.5 Extension

The Plan may extend the 3-working-Days' time period by up to 14 calendar Days if the Enrollee requests an extension, or if the Plan justifies a need for additional information and how the extension is in the Enrollee's interest (upon Agency request).

1.3.1.8.3.6 Untimely Service Authorization Decisions

The Plan must give notice on the date that the timeframes expire when Service Authorization decisions not reached within the timeframes for either standard or expedited Service Authorizations. Untimely Service Authorizations constitute a denial and are thus adverse Actions.

1.3.1.8.4 Grievance Process General Requirements

The Plan must:

1) Give Enrollees any reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. This includes providing a full and complete explanation of the process to the Enrollee;

2) Acknowledge receipt of each Grievance. For purposes of this Section, an Inquiry shall not be considered to be a Grievance unless the Enrollee expresses dissatisfaction in some way;

3) Ensure that decision makers on Grievances;

a) were not involved in any previous levels of review or decision-making, and

b) are Dental Care Professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

- a denial of service was based on lack of Necessary Dental Services;
- a Grievance regarding denial of expedited resolutions of an Appeal;
- any Grievance involving clinical issues.

4) Inform the Enrollee of the disposition of the Grievance in a format approved by the Agency; and

5) Inform the Enrollee of the availability of the Plan Appeal Process and the State fair hearing process.

1.3.1.8.4.1 Grievance System: Record keeping and reporting

The Plan must maintain records of Grievances and Appeals. Such records will be made available to the Agency upon request. A log of all Grievance and Appeals shall be delivered to the Agency as required of this Contract.

1.3.1.8.5 Grievance Appeals and State Fair Hearings

1.3.1.8.5.1 Filing a Grievance or Appeal

The Contractor shall allow the member, member's authorized representative or estate representative of a deceased member, including a provider who has the member's written consent, to file a grievance or Appeal and to be parties. Contractor shall allow the enrollee, or authorized representative, to file an Appeal either orally or in writing, and unless an expedited resolution is requested, follow the oral filing with a written, signed Appeal. Contractor shall treat oral inquiries seeking to Appeal an Action as Appeals, and shall confirm in writing unless the enrollee or authorized representative requests expedited resolution. Contractor shall not require that the enrollee, or authorized representative, follow an oral request for an expedited Appeal with a written, signed Appeal. Contractor shall permit an Appeal to be filed with the Contractor within 60 days from the date on the Contractor's notice of Action. The Contractor shall provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services, and toll-free numbers that have adequate TTY/TTD and interpreter capability.

1.3.1.8.5.2 Resolution and Notification

The Plan must resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires, within Agency-established timeframes not to exceed 30 Days from the Day the Plan receives the Appeal unless that timeframe is extended consistent with 42 C.F.R. § 438.408. Expedited Appeals must be resolved no later than 72 hours from receipt of the Appeal unless that timeframe is extended consistent with 42 C.F.R. § 438.408.

1.3.1.8.5.3 Format and Content of Resolution Notice

The Plan must provide written notice of disposition. The written resolution notice must include:

- The results and date of the Appeal resolution.
- For decisions not wholly in the Enrollee's favor:
  - The right to request a Fair hearing;
  - How to request a Fair hearing;
  - The right to continue to receive benefits pending a hearing;
  - How to request the continuation of benefit; and
  - If the Plan's Action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

1.3.1.8.5.4 Continuation of benefits

The Plan must continue the Enrollee's benefits if:

- The Appeal is filed timely, meaning on or before the later of the following:
  - within the time period established by the Plan pursuant to Section 1.3.1.8.5.2; or
  - the intended effective date of the Plan's proposed Action.
- The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized Provider;
- The authorization period has not expired; and
- The Enrollee requests extension of benefits.
  - Within 10 Days of the Plan mailing the notice of Action.

- the intended effective date of the Plan's proposed Action.

1.3.1.8.5.5 Duration of continued or reinstated benefits

If the Plan continues or reinstates the Enrollee's benefits while the Appeal is pending, the benefits must be continued until one of following occurs:

- The Enrollee withdraws the Appeal;
- The Enrollee does not request a fair hearing within 10 Days from when the Plan mails an adverse Plan decision;
- A Fair hearing decision adverse to the Enrollee is made; or
- The authorization expires or authorization service limits are met.

1.3.1.8.5.6 Enrollee responsibility for services furnished while the Appeal is pending

The Plan may recover the cost of the continuation of services furnished to the Enrollee while the Appeal was pending if the final resolution of the Appeal upholds the Plan's Action.

1.3.1.8.5.7 Effectuation when services were not furnished

The Plan must authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires if the services were not furnished while the Appeal is pending and the Plan or the fair hearing officer reverses a decision to deny, limit, or delay services.

1.3.1.8.5.8 Effectuation when services were furnished

The Plan must pay for disputed services, in accordance with State policy and Regulations, if the Plan or the Fair hearing officer reverses a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending.

1.3.1.8.6 Expedited Appeal Process

1.3.1.8.6.1 General

The Plan must establish and maintain an expedited review process for Appeals, when the Plan determines (for a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

1.3.1.8.6.2 Authority to File

The Enrollee or Provider may file an expedited Appeal either orally or writing. No additional Enrollee follow-up is required.

1.3.1.8.6.3 Resolution and notification

The Plan must resolve each expedited Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within Agency-established timeframes not to exceed 3 working Days after the Plan receives the Appeal.

1.3.1.8.6.4 Requirements following extension

For any extension not requested by the Enrollee, the Plan must give the Enrollee written notice of the reason for the delay.

1.3.1.8.6.5 Format of resolution notice

In addition to written notice, the Plan must also make reasonable efforts to provide oral Notice.

1.3.1.8.6.6 Punitive Action

The Plan must ensure that punitive action is not taken against a Provider who either requests an expedited resolution or supports an Enrollee's Appeal.

1.3.1.8.6.7 Action following denial of a request for expedited resolution

If the Plan denies a request for expedited resolution of an Appeal, it must:

- Transfer the Appeal to the standard timeframe of no longer than 45 Days from the Day the Plan receives the Appeal with a possible 14-Day extension (see 438.408(b)(2)); and
- Give the Enrollee prompt oral notice of the denial (make reasonable efforts) and a written notice within two calendar Days.

1.3.1.8.7 State Fair Hearing Process

- In accordance with 42 C.F.R. § 438.408, the State maintains a fair hearing process that allows members the opportunity to appeal the Contractor's decisions to the State. The member must first exhaust the Contractor's appeals process before gaining access to the state fair hearing process.
- An Enrollee may request a State fair hearing.
- The Provider may request a State fair hearing only if the Agency permits the Provider to act as the Enrollee's authorized representative.
- The Agency must permit the Enrollee to request a State fair hearing within a reasonable time period specified by the Agency as within 30 Days from the Plan's final decision.
- The State must reach its decisions within the specified timeframes:
- Standard resolution: within ninety (90) Days of the date the Enrollee filed the Appeal with the Plan if the Enrollee filed initially with the Plan (excluding the Days the Enrollee took to subsequently file for a Fair hearing) or the date the Enrollee filed for direct access to a Fair hearing.
- Expedited resolution (if the Appeal was heard first through the Plan Appeal Process): within three (3) working Days from agency receipt of a hearing request for a denial of a service that:
    - Meets the criteria for an expedited Appeal Process but was not resolved using the Plan's expedited Appeal timeframes, or
    - Was resolved wholly or partially adversely to the Enrollee using the Plan's expedited Appeal timeframes.
- Expedited resolution (if the Appeal was made directly to the Fair hearing process without accessing the Plan Appeal Process): within three (3) working Days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited Appeal Process.

Fair hearing: Parties - The parties to the State fair hearing include the Plan as well as the Enrollee and his or her representative or the representative of a deceased Enrollee's estate.
The Plan shall develop and implement written policies and procedures that detail the operation of the Grievance System and provides simplified instructions on how to file a Grievance or Appeal and how to request a fair hearing.

1.3.1.8.8 Record Keeping and Reporting Requirements:

The Plan shall log and track all inquiries, Grievances, and Appeals. The Plan shall maintain records of Grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of Grievance, date of decision, and the disposition.

The Plan shall maintain records of Appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of Appeal, date of decision, and the resolution. The Plan must report Grievances and Appeals to the Agency in the format and frequency specified by the Agency as specified in this Contract. The Agency shall provide the Plan with no less than ninety (90) days' notice of any change in the format or frequency requested. The Agency may publicly disclose summary information regarding the nature of Grievances.

1.3.1.9 Marketing

The Plan shall submit Enrollee marketing materials and any plans for marketing activities associated with the Dental Wellness Plan and program to the Agency for written approval prior to the distribution of the materials or conducting the activities. The Plan shall not have any unsolicited contact with a potential Enrollee by an employee or agent of the Plan for the purpose of influencing the individual to enroll with the Plan. When conducting marketing activities, the Plan shall clearly identify that the Plan is not acting as a representative of the Agency, and is acting on behalf of the Plan. The Plan must specify the methods by which the Plan assures the Agency that marketing, including plans and materials, is accurate and does not mislead, confuse or defraud the Enrollees or the Agency.

The Plan shall not obtain enrollment through the offer of any compensation, reward or benefit to the Enrollee except for the offer of Covered Services in addition to those identified in Section 1.3.1.4.

The Plan shall distribute any approved marketing materials to its entire service area. The Plan shall not seek to influence enrollment in the Plan in conjunction with the sale or offering of any private insurance. The Plan shall not directly or indirectly, engage in door-to-door, telephone, or other cold-call marketing activities.

1.3.1.9.1 Provider Communication Review and Approval

All Contractor developed provider communications shall be pre-approved by the Agency. Unless otherwise requested by the Agency, all materials shall be submitted at least thirty (30) calendar days prior to expected use and distribution. All substantive changes to previously approved communications shall also be submitted to the Agency for review and approval at least thirty (30) calendar days prior to use. The Contractor shall comply with any the Agency processes implemented to facilitate submission and approval of materials. For example, the Agency may opt to mandate use of an inventory control number on all submissions or the use of specific cover sheets with document submission. The Agency may waive the right to review and approve provider communications.

Information that includes the State's name and correspondence that may be sent to providers on behalf of the Agency shall also be submitted by the Contractor for the Agency review and approval. Any approval given for the Agency or other State agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval. The Contractor shall include the State program logo(s) in their provider communication materials upon the Agency request. The Agency reserves the right to mandate that specific language be included in provider communication materials.

1.3.1.10 Fraud and Abuse

The Plan shall diligently safeguard against the potential for and promptly investigate reports of suspected fraud and abuse by employees, subcontractors, Providers and other entities.

The Plan shall provide the Agency with the Plan’s policies and procedures on fraud and abuse within thirty (30) Days of execution of this Contract and whenever there is a change in the policy or procedure. This shall include the policy or procedure used to attest the accuracy, completeness and truthfulness of claims and payment data. The Plan shall notify the Agency, CMS, or the Office of the Inspector General, as appropriate, of all founded fraud and abuse cases within the Plan relevant to the Iowa Wellness Plan program. With respect to Enrollees, the reporting requirement applies to information on violations of the law that pertain to enrollment in the Plan, or the provision of, or payment for, health services.

The Plan shall comply with all applicable federal and state standards pertaining to fraud and abuse. The Agency may inspect, evaluate and audit the Plan at any time, as necessary, in instances where the Agency determines there is a reasonable possibility of fraudulent and abusive activity.

The Plan shall submit a monthly report to the Agency that includes the following:

- Number of complaints of fraud and abuse made to the Agency that warrant preliminary investigation
- For each warrants investigation, supply the
    - Name and ID number
    - Source of complaint
    - Type of provider
    - Nature of complaint
    - Approximate dollars involved
    - Legal and administrative disposition of the case.

1.3.1.11 Quality Improvement Program

The Plan shall maintain a Quality Improvement (QI) program that achieves, through ongoing measurement and intervention, demonstrable and sustained improvement in projects concerning significant aspects of non-clinical services that can be expected to affect Enrollee satisfaction. Noted improvement shall be related to the QI projects rather than a random occurrence.

The Plan shall provide a description of the QI program, which shall evaluate, for the purpose of improvement, the overall quality of Plan services and processes to the Agency. These QI plans shall identify potential reasons for sub-optimal performance, opportunities for improvement, proposed activities to be performed within the scope of the QI program, and timeline for such activities.

A summary of the Plan's QI actions shall be submitted to the Agency no later than April 1, 2015, and April of each Contract year thereafter.

1.3.1.12 Dental Education and Prevention

Within 20 days of the beginning of each Contract year, the Plan shall submit a description of its dental education and prevention program and record of related activities to the Agency for review. The Plan's dental education and prevention program shall be consistent with state licensure standards. The Plan shall provide to Enrollees recommended guidelines and information regarding preventive dental benefits and/or practices.

1.3.1.13 Practice Guidelines and New Technology

If a Plan adopts and enforces clinical practice guidelines, the Plan shall outline the mechanism for the adoption of the guidelines. Guidelines shall be based on reasonable dental evidence or a consensus of relevant practitioners and shall be reviewed and updated periodically. The Plan must ensure that decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines. The guidelines shall be communicated to Providers and as necessary to Enrollees through manuals, newsletters or other communications.

The Plan shall have a written policy for review and adoption of new technologies and new uses of existing technologies. The policy shall be based on scientific evidence, review of findings by the Food and Drug Administration and other regulatory bodies, Title XIX coverage decisions and in consultation with medical professionals. The policy shall be communicated to Providers of services.

Clinical practice guidelines and technology review policies shall not exclude any Necessary Dental Services as defined herein.

1.3.1.14 Other Contracts

The Plan shall reasonably cooperate with other contractors retained by the Agency.

1.3.1.15 Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR part 2 Compliance

The Plan performs certain services on behalf of or for the Agency pursuant to this Contract that require the exchange of information about patients that is protected by the Health Insurance Portability and Accountability Act of 1996. The Contractor, acting as the Agency's Business Associate, agrees to be bound by and comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Agency's website:

http://www.dhs.state.ia.us/Consumers/Health/HIPAA/Home.html.

The Business Associate Agreement Addendum is incorporated herein by reference. By signing this Contract, the Contractor consents to receive notice of future amendments to the BAA through electronic mail. The Contractor shall file and maintain a current electronic mail address with the Agency for this purpose. The Agency may amend the BAA by posting an updated version of the BAA on the Agency's website at the above web address, and providing the Business Associate electronic notice of the amended BAA. The Business Associate shall be deemed to have accepted the amendment unless the Business Associate notifies the Agency of its non-acceptance in accordance with the Notice provisions of the Contract within 30 days of the Agency's notice referenced herein. Any agreed alteration of the then current Agency BAA shall have no force or effect until the agreed alteration is reduced to a Contract amendment that must be signed by the Contractor, Agency Director, and the Agency Security and Privacy Officer.

Notwithstanding any references in the Business Associate Agreement incorporated herein by reference, disclosures made at the Agency's direction that violate the Privacy Standards shall not trigger Dental dental's indemnification obligation.

Qualified Service Organization. The Contractor acknowledges that it will be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2, and the Contractor acknowledges that it is fully bound by those regulations. The Contractor will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 CFR part 2. **"**Qualified Service Organization" as used in this Contract has the same meaning as the definition set forth in 42 CFR § 2.11.

1.3.1.15 Periodic Reports

The Plan agrees to furnish information, which may be required to administer this Contract to the Agency or the Agency's authorized agents.

Unless otherwise specified, the following periodic reports shall be submitted to the Agency within sixty (60) Days from the end of the time period for which the report is to cover. In the event that delays in periodic report submissions are caused by the Agency, the time frame for submission shall be extended by the length of the delay.

1. Encounter data shall be submitted monthly to the Agency by the 15th of each month for the previous months claim activity in a format agreed upon by both parties.
2. Summaries of appeals and resolutions shall be submitted at the end of each State Fiscal Year Quarter in accordance with Section 1.3.1.8.8.
3. Summaries of the Plan's QI and dental education and prevention programs shall be submitted to the Agency no later than April 1 of each Contract Year.
4. To the extent not precluded by law or Plan's agreement with Provider, information regarding disciplinary actions against participating Providers by any state licensing board if discovered by the Plan shall be submitted to the Agency.
5. A provider directory in the format agreed upon by both parties at least quarterly. This may be submitted monthly with the encounter data files. The Plan shall demonstrate to the Agency's

satisfaction compliance with 42 U.S.C.A. § 1396u-2(b)(5)(B) by showing a sufficient number, mix and geographic distribution of providers of services.

6. Dental data needed to complete the CMS 416 report for Enrollees ages 19 and 20 years old shall be submitted to the Agency by November 15th of each Contract year.

1.3.1.16 Access to Dental Records

The Enrollees, their attorney or their authorized representative shall be provided timely access to the Enrollee's dental records maintained by the Plan in accordance with applicable federal and state laws.

The Plan shall provide dental records to the Agency for the purposes described in Section 2.13.25 of this Contract. The Plan shall obtain the necessary releases of information from the Enrollee, their attorney or their authorized representative to release the dental records to the Agency.

The Plan shall provide the Agency, CMS and/or the Health and Human Service Office of the Inspector General with access to Iowa Wellness Plan Enrollee's dental claims data, claim payment data and related records.

1.3.1.17 Access to Premises, Audits and Inspections

The Plan shall allow duly authorized and identified agents or representatives of the state and federal governments including CMS, the Office of Civil Rights, and the Health and Human Service Office of the Inspector General, access to the Plan's premises during normal business hours for the specific purpose of inspecting, auditing, monitoring, or otherwise evaluating the performance of the Plan pursuant to this Contract. The Plan agrees to produce records, including, but not limited to, medical records as referenced in 2.13.25, relevant to this Section. In the event assess to Plan's requested under this Section, the Plan agrees to make staff available to assist in the audit or inspecting effort and to provide adequate space on the premises to reasonably accommodate the state or federal representatives conducting the audit or inspection.

The Agency shall uses its best efforts to notify the Plan, in writing, thirty (30) Days in advance of any inspection or audit, but reserves the right, when necessary in the Agency's judgment, to conduct audits or inspections pursuant to advance written notice of less than thirty (30) Days.

All audits or inspections shall be limited to a reasonable duration and conducted in a manner that does not unduly interfere with the Plan's regular business activities.

The Plan shall be given thirty (30) Days to respond in writing to any audit or inspection findings preceding finalization of same. All information so obtained shall be accorded confidential treatment as provided under applicable law.

1.3.1.18 Protections Against Fraud and Abuse

For purposes of this subsection, an "Excluded Person" means a person who (i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12349 or under guidelines implementing such order, or (ii) an affiliate (as defined in such Regulations) of a person described in section (i) of this definition.

The Plan shall not knowingly have: (a) an Excluded Person as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Plan's equity, or (b) an employment, consulting, or other agreement with an Excluded Person of the provision of items and services that are significant and material to the Plan's obligations under this Contract.

If the Agency finds that the entity has violated this requirement, the Agency will notify the Secretary of Health and Human Services of the violation and the Secretary, in consultation with the State and the Inspector General, will decide if this Contract will continue or otherwise be terminated.

Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or CHIP, except for emergency services.

Neither the Plan nor subcontractors or employees, agents, or assignees may contract with any entity that is under sanction by the Agency. The Plan shall periodically check for sanction providers.

Neither the Plan nor subcontractors or employees, agents, or assignees may contract with any entity that is subject to mandatory sanction by the Agency.

1.3.1.19 Compliance with Other State and Federal Laws and Regulations

The Plan must comply with all applicable federal and state laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities): the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act. The Plan must comply with any other applicable federal and state laws and other laws regarding privacy and confidentiality. The Plan must comply with any applicable federal and state laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to Enrollees.

1.3.1.20 Reporting Violations of Law

The Plan shall report to the Agency, to CMS, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or Enrollees of the Plan and other individuals.

1.3.1.21 Disclosure of Ownership and Related Information

(a)(1) The Plan shall—

(A) supply the Agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 percent or more ownership interest and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 42 U.S.C.A. § 405(c)(2)(B)) of the Plan, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.

(2) As used in this section, the term "disclosing entity" means an entity which is—

(A) a provider of services (as defined in 42 U.S.C.A. § 1395x(u) other than a fund), an independent clinical laboratory, a renal disease facility, a managed care entity, as defined in 42 U.S.C.A. § 1396u-2(a)(1)(B), or a health maintenance organization (as defined in 42 U.S.C.A. §300e(a)).

(B) an entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, items or services with respect to which payment may be claimed by the entity under any plan or program established pursuant to Title V or under a State plan approved under Title XIX; or

(C) a carrier or other agency or organization that is acting as a fiscal intermediary or agent with respect to one or more providers of services (for purposes of part A or part B of Title XVIII, or both, or for purposes of a State plan approved under Title XIX) pursuant to (i) an agreement under 42 U.S.C.A. § 1395h, (ii) a contract under 42 U.S.C.A. § 1395u, or (iii) an agreement with a single State agency administering or supervising the administration of a State plan approved under Title XIX.

(3) As used in this section, the term "person with an ownership or control interest" means, with respect to an entity, a person who—

(A)(i) has directly or indirectly (as determined by the Secretary in regulations) an ownership interest of 5 per centum or more in the entity; or (ii) is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or

(B) is an officer or director of the entity, if the entity is organized as a corporation; or

(C) is a partner in the entity, if the entity is organized as a partnership.

(b) To the extent determined to be feasible under regulations of the Secretary, a disclosing entity shall also include in the information supplied under subsection (a)(1) of this Section with respect to each person with an ownership or control interest in the entity, the name of any other disclosing entity with respect to which the person is a person with an ownership or control interest.

1.3.1.22 Advisory Council for the Dental Wellness Plan

The Plan shall convene and facilitate an advisory council within ninety (90) days of the effective date of the Contract. The purpose of the Advisory Council is to serve as a forum for providers and stakeholders to advise the Plan. The Advisory Council shall meet each three times during this contract term and provide input on issues (i) develop strategies for whole-person care facilitation: (ii) evaluate the plan's impact, and, as needed, to develop recommendations regarding steps for improvement. The Plan shall submitted to the Agency comprehensive and complete meeting minutes no later than 30 days following the conclusion of each such meeting. The advisory council shall include the following: representative from the Agency, representatives from the Plan, representatives from the Department of Public Health, dentists, safety net providers, enrollees, and stakeholders.

1.3.1.23 Meeting Outcomes

The Contractor shall utilize feedback obtained from the Advisory Council in the development and implementation of process improvement strategies and to inform policy and procedure development and modification. Issues raised by stakeholders shall be incorporated into the Contractor's quality assessment and performance improvement program and into other Contractor operational planning and management activities as indicated by the nature of the input. On a quarterly basis the Plan shall meet with the Agency and provide a written report, identifying how the information gathered from the Advisory Council will be used to improve quality, and access and the Plan's strategies for addressing stakeholder concerns identified in the Advisory Council meeting.

1.3.2 Performance Measures.

Failure to meet the following performance measures shall not be deemed a breach of this Agreement. The Parties will meet and discuss periodically the efficacy of the performance measures and, if necessary, establish performance measures that are reasonably achievable based on Plan experience. The Plan shall deliver a report detailing each performance measure in accordance with the required reports as outlined in the Reporting Manual.

1.3.2.1 Access

A. Within each Contract year, at least 40 percent of Enrollees who have had continuous enrollment with the Plan for at least six months shall have received at least one dental service.
B. Of the Enrollees identified in Section 1.3.2.1(A), at least 90 percent of those Enrollees have a preventive exam within each Contract year.
C. Twenty-five percent of Enrollees who are eligible to receive a follow up preventive exam will return within six to twelve months of their initial exam within each Contract year.
D. Forty-five percent of Enrollees who have had an emergency service or stabilization service will have a preventive exam within each Contract year.

E. Forty (40) percent of Enrollees will have at least one (1) dental exam in each reporting year (based on nine (9) months continuous eligibility).

1.3.3 Monitoring, Review, and Problem Reporting.

1.3.3.1 Agency Monitoring Clause. The Contract Manager or designee will:

- Verify Invoices and supporting documentation itemizing work performed prior to payment;
- Determine compliance with general contract terms, conditions, and requirements; and
- Assess compliance with Deliverables, performance measures, or other associated requirements based on the following:

  The Agency shall monitor for the receipt of the performance measure reports and analyze the reports to determine if the performance measures were met.

1.3.3.2 Agency Review Clause. The Contract Manager or designee will use the results of monitoring activities and other relevant data to assess the Contractor's overall performance and compliance with the Contract. At a minimum, the Agency will conduct a review annually; however, reviews may occur more frequently at the Agency's discretion. As part of the review(s), the Agency may require the Contractor to provide additional data, may perform on-site reviews, and may consider information from other sources.

The Agency may require one or more meetings to discuss the outcome of a review. Meetings may be held in person. During the review meetings, the parties will discuss the Deliverables that have been provided or are in process under this Contract, achievement of the performance measures, and any concerns identified through the Agency's contract monitoring activities.

1.3.3.2 Problem Reporting. As stipulated by the Agency, the Contractor and/or Agency shall provide a report listing any problem or concern encountered. Records of such reports and other related communications issued in writing during the course of Contract performance shall be maintained by the parties. At the next scheduled meeting after a problem has been identified in writing, the party responsible for resolving the problem shall provide a report setting forth activities taken or to be taken to resolve the problem together with the anticipated completion dates of such activities. Any party may recommend alternative courses of action or changes that will facilitate problem resolution. The Contract Owner has final authority to approve problem-resolution activities.

The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

1.3.3.3 Addressing Deficiencies. To the extent that Deficiencies are identified in the Contractor's performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a plan acceptable to the Agency to resolve the Deficiencies.

1.3.4 Contract Payment Clause.

1.3.4.1 Pricing. In accordance with the payment terms outlined in this section and Contractor's completion of the Scope of Work as set forth in this Contract, payment will occur as follows:

1.3.4.2 Payment Methodology.

1.3.4.2.1 Capitation Rate Payments.

The Contractor shall be paid a monthly capitation payment as set forth in Table immediately below:

Capitation Rates

Time Period	PMPM Rate
5/1/2015 – 6/30/2015	**$22.66**
7/1/2015 – 6/30/2016	**$26.06**
7/1/2016 – 6/30/2017	**$27.35**

The capitation payment shall be payment in full for the Plan's Covered Services for the Enrollees in the Plan listed in the monthly HIPAA 820 capitation file. Retroactive adjustments to reflect the actual cost of Covered Services are prohibited.

The Plan shall on a monthly basis reconcile the monthly HIPAA 820 capitation file with the Plan's enrollment records. Any discrepancies found between the monthly HIPAA 820 capitation file and the Plan's enrollment records shall be reported to the Agency within sixty (60) calendar days from the end of the quarter. No adjustment to the capitation payment shall be made for any discrepancies reported after the sixty (60) calendar day period.

The monthly capitation rate shall be subject to review annually during the Contract term or when the scope of Covered Services is changed by the parties. *See, e.g.,* Section 1.3.1.4. If changes are made in the Covered Services, the parties shall renegotiate the capitation rate to take the change into account. If the Agency establishes new capitation rates, such rates shall be established at least forty-five (45) calendar days prior to the effective date. The Plan shall notify the Agency thirty (30) days after receiving notice of the new rates regarding its intent to continue the Contract.

1.3.4.2.2 Medical Loss Ratios & Risk Corridors.

Capitation payments made through the Contract shall be subject to the following Medical Loss Ratios ("MLRs") and risk corridors for the stated Contract periods set forth in the Table immediately below:

MLRs & Risk Corridors

Date Range	Applicable MLR	Risk Corridor
5/1/2014 – 6/30/2015	87.5%	2.5%
7/1/2015 – 6/30/2016	88.5%	2.5%
7/1/2016 – 6/30/2017	89.5%	2.5%

For Contract years prior to State Fiscal Year 2017 (SFY2017), the MLR shall be defined as the ratio of medical costs to capitation revenue. For any such Contract period, "medical costs" include payment for the direct cost of care, provider incentive bonus payments, and the direct costs of community and member outreach referral services.

For the Contract year beginning with SFY2017, the MLR shall be defined as the ratio of medical costs to capitation revenue, calculated as follows:

The Agency shall determine the Medical Costs using the following data:

- Paid Claims. Paid Claims shall be included in Medical Costs. The Agency shall use Encounter Data claims for all dates of service during the Coverage Year and accepted by the Agency within six (6) months after the end of the Coverage Year. If the Contractor and Agency are unable to resolve Encounter Data systems issues prior to calculation of the MLR, a mutually agreed upon alternative method of

calculating paid claims expense will be used. Encounter Data claims covered by sub-capitation contracts shall be priced at Contractor's Fee-For-Service rate for Covered Services or the Agency's designated pricing. Contractor shall provide clear supporting documentation of these sub-capitated arrangements.

- Incurred But Not Paid Claims. Claims that have been incurred but not paid (IBNP), as submitted by the Contractor. The Agency's actuary will review this submission for accuracy and reasonableness.

The Agency shall determine the Capitation Revenue using the following data:

Capitation Revenue. The capitation revenue used in the Medical Loss Ratio calculation will consist of the Capitation payments made to the Contractor adjusted to exclude the outreach and communication plan funds, and capitation payments amounts related to the ACA health insurer fee, including amounts withheld. Provider incentive plan amounts will be included in the Medical Loss Ratio calculation.

In all Contract periods, the MLR shall be subject to a risk corridor as set forth in the table immediately above entitled "MLRs & Risk Corridors." The risk corridor will be calculated by adding and subtracting the risk corridor percentage to the applicable MLR for the Contract period. By way of example, if the MLR was 88% for a given year and the risk corridor was 2.5%, the upper band of the risk corridor range would be 90.5%, and the lower band would be 85.5%. Using this example, if the MLR calculation applicable in a given Contract year exceeded the upper band, the Agency would be obligated to pay the Contractor the difference between the MLR in that Contract year and the upper band of the risk corridor. Likewise, if the MLR calculation resulted in a value lower than the lower band of the risk corridor, the Contractor would be obligated to reimburse the Agency for the difference between the lower band value and the actual MLR for the Contract period. All risk corridor calculations shall be based on the Agency's review of eligibility, claims and encounter data.

1.3.4.3 Reimbursable Expenses. Unless otherwise agreed to by the parties in an amendment or change order to the Contract that is executed by the parties, the Contractor shall not be entitled to receive any other payment or compensation beyond the agreed to capitation rate from the State for any Deliverables provided by or on behalf of the Contractor pursuant to this Contract. The Contractor shall be solely responsible for paying all costs, expenses, and charges it incurs in connection with its performance under this Contract.

1.3.4.4 Beginning with State Fiscal Year 2017, the Agency will withhold a portion of the approved capitation payments from Contractor within each Contract period. The withheld amount shall be two percent (2%) of the monthly capitation payment. The Contractor will be eligible to receive some or all of the withheld funds based on the Contractor's performance in the areas outlined in the table immediately below.. These performance standards require the Contractor to exceed the minimum performance standard required for Contract compliance and incentivize the Contractor to perform at a higher level in two (2) areas determined by the Agency to be critical for successful program. Measures will be paid based on custom Specifications developed by the Agency and performance will be determined by the Agency or its designee. The Contractor shall submit information to the Agency, in the format and timeframe specified by the Agency, with respect to each performance measure set forth below. Any data received after the required submission date will not be eligible for an incentive payment. Incentive payments will be payable in the form of release of funds withheld.

Operational Pay for Performance Measures

Performance Measure	Required Contractual Standard	Withhold Payment Obligation

Performance Measure	Required Contractual Standard	Withhold Payment Obligation	
Access	**Section 1.3.2.1.A:** Within each Contract year, at least 40 percent of Enrollees who have had continuous enrollment with the Plan for at least six months shall have received at least one dental service.	**Perf. Level**	**Percentage of Withhold Payable**
		40% or above	**50%**
		39%	**40%**
		38%	**30%**
		37%	**20%**
		36%	**10%**
		35% or below	**0%**
Access	**Section 1.3.2.1.B:** Of the Enrollees identified in Section 1.3.2.1(A), at least 90 percent of those Enrollees have a preventive exam within each Contract year.	**Perf. Level**	**Percentage of Withhold Payable**
		90% or above	**30%**
		89%	**25%**
		88%	**20%**
		87%	**15%**
		86%	**10%**
		85% or below	**0%**
Access	**Section 1.3.2.1.C: C.** Twenty-five percent of Enrollees who are eligible to receive a follow up preventive exam will return within six to twelve months of their initial exam within each Contract year.	**Perf. Level**	**Percentage of Withhold Payable**
		25% or above	**20%**
		24%	**15%**
		23%	**12%**
		22%	**10%**
		21%	**5%**
		20% or below	**0%**

1.4 Insurance Coverage.

The Contractor and any subcontractor shall obtain the following types of insurance for at least the minimum amounts listed below:

Type of Insurance	Limit	Amount
General Liability (including contractual liability) written on occurrence basis	General Aggregate Product/Completed Operations Aggregate Personal Injury Each Occurrence	$2 Million $1 Million $1 Million $1 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	$1 Million
Excess Liability, Umbrella Form	Each Occurrence Aggregate	$1 Million $1 Million
Workers' Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law

Property Damage	Each Occurrence Aggregate	$1 Million $1 Million
Professional Liability	Each Occurrence Aggregate	$2 Million $2 Million

SECTION 2. GENERAL TERMS FOR SERVICES CONTRACTS

2.1 Definitions. Definitions in this section correspond with capitalized terms in the Contract.

"Acceptance" means that the Agency has determined that one or more Deliverables satisfy the Agency's Acceptance Tests. Final Acceptance means that the Agency has determined that all Deliverables satisfy the Agency's Acceptance Tests. Non-acceptance means that the Agency has determined that one or more Deliverables have not satisfied the Agency's Acceptance Tests.
"Acceptance Criteria" means the Specifications, goals, performance measures, testing results and/or other criteria designated by the Agency and against which the Deliverables may be evaluated for purposes of Acceptance or Non-acceptance thereof.
"Acceptance Tests" or "Acceptance Testing" mean the tests, reviews, and other activities that are performed by or on behalf of the Agency to determine whether the Deliverables meet the Acceptance Criteria or otherwise satisfy the Agency, as determined by the Agency in its sole discretion.
"Bid Proposal" or "Proposal" means the Contractor's proposal submitted in response to the Solicitation, if this Contract arises out of a competitive process.
"Business Days" means any day other than a Saturday, Sunday, or State holiday as specified by Iowa Code §1C.2.
"Confidential Information" means, subject to any applicable State and federal laws and regulations, including but not limited to Iowa Code Chapter 22, any confidential or proprietary information or trade secrets disclosed by either party (a "Disclosing Party") to the other party (a "Receiving Party") that, at the time of disclosure, is designated as confidential (or like designation), is disclosed in circumstances of confidence, or would be understood by the parties, exercising reasonable business judgment, to be confidential. Regardless of whether or not the following information is designated as confidential, the term Confidential Information includes information that could be used to identify recipients or applicants of Agency services and recipients of Contract services including Protected Health Information (45 C.F.R. § 160.103) and Personal Information (Iowa Code § 715C.1(11)), Agency security protocols and procedures, Agency system architecture, information that could compromise the security of the Agency network or systems, and information about the Agency's current or future competitive procurements, including the evaluation process prior to the formal announcement of results.

Confidential Information does not include any information that: (1) was rightfully in the possession of the Receiving Party from a source other than the Disclosing Party prior to the time of disclosure of the information by the Disclosing Party to the Receiving Party; (2) was known to the Receiving Party prior to the disclosure of the information by the Disclosing Party; (3) was disclosed to the Receiving Party without restriction by an independent third party having a legal right to disclose the information; (4) is in the public domain or shall have become publicly available other than as a result of disclosure by the Receiving Party in violation of this Agreement or in breach of any other agreement with the Disclosing Party; (5) is independently developed by the Receiving Party without any reliance on Confidential Information disclosed by the Disclosing Party; (6) is disclosed or is required or authorized to be disclosed pursuant to law, rule, regulation, subpoena, summons, or the order of a court, lawful custodian, governmental agency or regulatory authority, or by applicable regulatory or professional standards; or (7) is disclosed by the Receiving Party with the written consent of the Disclosing Party.
"Contract" means the collective documentation memorializing the terms of the agreement between the Agency and the Contractor identified in the Contract Declarations and Execution Section and includes the signed Contract Declarations and Execution Section, the General Terms for Services Contracts, the Special Terms, and any Special Contract Attachments.
"Declarations and Execution Section" means the document that contains basic information about the Contract and incorporates by reference the General

Terms for Services Contracts, the Special Terms, and any Special Contract Attachments.

"Deficiency" means a defect, flaw, anomaly, failure, omission, interruption of service, or other problem of any nature whatsoever with respect to a Deliverable, including, without limitation, any failure of a Deliverable to conform to or meet an applicable specification. Deficiency also includes the lack of something essential or necessary for completeness or proper functioning of a Deliverable.

"Deliverables" means all of the services, goods, products, work, work product, data, items, materials and property to be created, developed, produced, delivered, performed, or provided by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) in connection with this Contract. This includes data that is collected on behalf of the Agency.

"Documentation" means any and all technical information, commentary, explanations, design documents, system architecture documents, database layouts, test materials, training materials, guides, manuals, worksheets, notes, work papers, and all other information, documentation and materials related to or used in conjunction with the Deliverables, in any medium, including hard copy, electronic, digital, and magnetically or optically encoded media.

"Force Majeure" means an event that no human foresight could anticipate or which if anticipated, is incapable of being avoided. Circumstances must be abnormal and unforeseeable, so that the consequences could not have been avoided through the exercise of all due care. The delay or impossibility of performance must be beyond the control and without the fault or negligence of the parties. Force Majeure does not include: financial difficulties, strikes, labor unrest, or supply chain disruptions.

"Invoice" means a Contractor's claim for payment. At the Agency's discretion, claims may be submitted on an original invoice from the Contractor or may be submitted on a claim form acceptable to the Agency, such as a General Accounting Expenditure (GAX) form.

"Solicitation" means the formal or informal procurement (and any Addenda thereto) identified in the Contracts Declarations and Execution Section that was issued to solicit the Bid Proposal leading to this Contract.

"Special Contract Attachments" means any attachment to this Contract indicated in the Contract Declarations and Execution Section.

"Special Terms" means the Section of the Contract entitled "Special Terms" that contains terms specific to this Contract, including but not limited to the Scope of Work and contract payment terms. If there is a conflict between the General Terms for Services Contracts and the Special Terms, the Special Terms shall prevail.

"Specifications" means all specifications, requirements, technical standards, performance standards, representations, and other criteria related to the Deliverables stated or expressed in this Contract, the Documentation, the Solicitation, and the Bid Proposal. Specifications shall include the Acceptance Criteria and any specifications, standards, or criteria stated or set forth in any applicable state, federal, foreign, and local laws, rules and regulations. The Specifications are incorporated into this Contract by reference as if fully set forth in this Contract.

"State" means the State of Iowa, the Agency, and all State of Iowa agencies, boards, and commissions, and when this Contract is available to political subdivisions, any political subdivisions of the State of Iowa.

2.2 Duration of Contract. The term of the Contract shall begin and end on the dates specified in the Contract Declarations and Execution Section, unless extended or terminated earlier in accordance with the termination provisions of this Contract. The Agency may, in its sole discretion, amend the end date of this Contract by exercising any applicable extension by giving the Contractor a written extension at least sixty (60) days prior to the expiration of the initial term or renewal term, subject to agreement between the parties on capitated rates as set forth in Section 1.3.4.2.

2.3 Scope of Work. The Contractor shall provide Deliverables that comply with and conform to the Specifications. Deliverables shall be performed within the boundaries of the United States.

2.4 Compensation.

2.4.1 Withholding Payments. In addition to pursuing any other remedy provided herein or by law, the Agency may withhold compensation or payments to the Contractor, in whole or in part, without penalty

to the Agency or work stoppage by the Contractor, in the event the Agency determines that: (1) the Contractor has failed to perform any of its duties or obligations as set forth in this Contract; (2) any Deliverable has failed to meet or conform to any applicable Specifications or contains or is experiencing a Deficiency; or (3) the Contractor has failed to perform Close-Out Event(s). No interest shall accrue or be paid to the Contractor on any compensation or other amounts withheld or retained by the Agency under this Contract.

2.4.2 Erroneous Payments and Credits. The Contractor shall promptly repay or refund the full amount of any overpayment or erroneous payment within thirty (30) Business Days after either discovery by the Contractor or notification by the Agency of the overpayment or erroneous payment.

2.4.3 Offset Against Sums Owed by the Contractor. In the event that the Contractor owes the State any sum under the terms of this Contract, any other contract or agreement, pursuant to a judgment, or pursuant to any law, the State may, in its sole discretion, offset any such sum against: (1) any sum Invoiced by, or owed to, the Contractor under this Contract, or (2) any sum or amount owed by the State to the Contractor, unless otherwise required by law. The Contractor agrees that this provision constitutes proper and timely notice under any applicable laws governing offset.

2.5 Termination.

2.5.1 Termination for Cause by the Agency. The Agency may terminate this Contract upon written notice for the breach by the Contractor or any subcontractor of any material term, condition or provision of this Contract, if such breach is not cured within the time period specified in the Agency's notice of breach or any subsequent notice or correspondence delivered by the Agency to the Contractor, provided that cure is feasible. In all instances in which a cure period is feasible, the Agency will first require that Contractor submit a plan pursuant to Section 1.3.3.4 to address the Deficiency. In addition, the Agency may terminate this Contract effective immediately without penalty and without advance notice, or opportunity to cure, or submission of a plan pursuant to Section 1.3.3.4 for any of the following reasons:

2.5.1.1 The Contractor furnished any statement, representation, warranty, or certification in connection with this Contract, the Solicitation, or the Bid Proposal that is false, deceptive, or materially incorrect or incomplete;

2.5.1.2 The Contractor or any of the Contractor's officers, directors, employees, agents, subsidiaries, affiliates, contractors or subcontractors has committed or engaged in fraud, misappropriation, embezzlement, malfeasance, misfeasance, or bad faith;

2.5.1.3 The Contractor or any parent or affiliate of the Contractor owning a controlling interest in the Contractor dissolves;

2.5.1.4 The Contractor terminates or suspends its business;

2.5.1.5 The Contractor's corporate existence or good standing in Iowa is suspended, terminated, revoked or forfeited, or any license or certification held by the Contractor related to the Contractor's performance under this Contract is suspended, terminated, revoked, or forfeited;

2.5.1.6 The Contractor has failed to comply with any applicable international, federal, state (including, but not limited to Iowa Code Chapter 8F), or local laws, rules, ordinances, regulations, or orders when performing within the scope of this Contract;

2.5.1.7 The Agency determines or believes the Contractor has engaged in conduct that: (1) has or may expose the Agency or the State to material liability; or (2) has caused or may cause a person's life, health, or safety to be jeopardized;

2.5.1.8 The Contractor infringes or allegedly infringes or violates any patent, trademark, copyright, trade dress, or any other intellectual property right or proprietary right, or the Contractor misappropriates or allegedly misappropriates a trade secret;

2.5.1.9 The Contractor fails to comply with any applicable confidentiality laws, privacy laws, or any provisions of this Contract pertaining to confidentiality or privacy; or

2.5.1.10 Any of the following has been engaged in by or occurred with respect to the Contractor or any corporation, shareholder or entity having or owning a controlling interest in the Contractor:

- Commencing or permitting a filing against it which is not discharged within ninety (90) days, of a case or other proceeding seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect; or filing an answer admitting the material allegations of a petition filed against it in any involuntary case or other proceeding commenced against it seeking liquidation, reorganization, or other

relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts; or consenting to any such relief or to the appointment of or taking possession by any such official in any voluntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts;

- Seeking or suffering the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its assets;
- Making an assignment for the benefit of creditors;
- Failing, being unable, or admitting in writing the inability generally to pay its debts or obligations as they become due or failing to maintain a positive net worth and such additional capital and liquidity as is reasonably adequate or necessary in connection with the Contractor's performance of its obligations under this Contract; or
- Taking any action to authorize any of the foregoing.

2.5.2 Termination Upon Notice. Following a thirty (30) day written notice, the Agency may terminate this Contract in whole or in part without penalty and without incurring any further obligation to the Contractor. Termination can be for any reason or no reason at all.

2.5.3 Termination Due to Lack of Funds or Change in Law. Notwithstanding anything in this Contract to the contrary, and subject to the limitations set forth below, the Agency shall have the right to terminate this Contract without penalty and without any advance notice as a result of any of the following:

2.5.3.1 The legislature or governor fail in the sole opinion of the Agency to appropriate funds sufficient to allow the Agency to either meet its obligations under this Contract or to operate as required and to fulfill its obligations under this Contract; or

2.5.3.2 If funds are de-appropriated, reduced, not allocated, or receipt of funds is delayed, or if any funds or revenues needed by the Agency to make any payment hereunder are insufficient or unavailable for any other reason as determined by the Agency in its sole discretion; or

2.5.3.3 If the Agency's authorization to conduct its business or engage in activities or operations related to the subject matter of this Contract is withdrawn or materially altered or modified; or

2.5.3.4 If the Agency's duties, programs or responsibilities are modified or materially altered; or

2.5.3.5 If there is a decision of any court, administrative law judge or an arbitration panel or any law, rule, regulation, or order is enacted, promulgated, or issued that materially or adversely affects the Agency's ability to fulfill any of its obligations under this Contract.

The Agency shall provide the Contractor with written notice of termination pursuant to this section.

2.5.4 Other remedies. The Agency's right to terminate this Contract shall be in addition to and not exclusive of other remedies available to the Agency, and the Agency shall be entitled to exercise any other rights and pursue any remedies, in law, at equity, or otherwise.

2.5.5 Limitation of the State's Payment Obligations. In the event of termination of this Contract for any reason by either party (except for termination by the Agency pursuant to Section 2.5.1, *Termination for Cause by the Agency*) the Agency shall pay only those amounts, if any, due and owing to the Contractor hereunder for Deliverables actually and satisfactorily provided in accordance with the provisions of this Contract up to and including the date of termination of this Contract and for which the Agency is obligated to pay pursuant to this Contract; provided however, that in the event the Agency terminates this Contract pursuant to Section 2.5.3, *Termination Due to Lack of Funds or Change in Law*, the Agency's obligation to pay the Contractor such amounts and other compensation shall be limited by, and subject to, legally available funds. Payment will be made only upon submission of Invoices and proper proof of the Contractor's claim. Notwithstanding the foregoing, this section in no way limits the rights or remedies available to the Agency and shall not be construed to require the Agency to pay any compensation or other amounts hereunder in the event of the Contractor's breach of this Contract or any amounts withheld by the Agency in accordance with the terms of this Contract. The Agency shall not be liable, under any circumstances, for any of the following:

2.5.5.1 The payment of unemployment compensation to the Contractor's employees;

2.5.5.2 The payment of workers' compensation claims, which occur during the Contract or extend beyond the date on which the Contract terminates;

2.5.5.3 Any costs incurred by the Contractor in its performance of the Contract, including, but not

limited to, startup costs, overhead, or other costs associated with the performance of the Contract;
2.5.5.4 Any damages or other amounts associated with the loss of prospective profits, anticipated sales, goodwill, or for expenditures, investments, or commitments made in connection with this Contract; or
2.5.5.5 Any taxes the Contractor may owe in connection with the performance of this Contract, including, but not limited to, sales taxes, excise taxes, use taxes, income taxes, or property taxes.
2.5.6 Contractor's Contract Close-Out Duties. Upon receipt of notice of termination, at expiration of the Contract, or upon request of the Agency (hereafter, "Close-Out Event"), the Contractor shall:
2.5.6.1 Cease work under this Contract and take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report within thirty (30) days of the Close-Out Event, describing the status of all work performed under the Contract and such other matters as the Agency may require.
2.5.6.2 Immediately cease using and return to the Agency any property or materials, whether tangible or intangible, provided by the Agency to the Contractor.
2.5.6.3 Cooperate in good faith with the Agency and its employees, agents, and independent contractors during the transition period between the Close-Out Event and the substitution of any replacement service provider.
2.5.6.4 Immediately return to the Agency any payments made by the Agency for Deliverables that were not rendered or provided by the Contractor.
2.5.6.5 Immediately deliver to the Agency any and all Deliverables for which the Agency has made payment (in whole or in part) that are in the possession or under the control of the Contractor or its agents or subcontractors in whatever stage of development and form of recordation such property is expressed or embodied at that time.
2.5.7 Termination for Cause by the Contractor. The Contractor may only terminate this Contract for the breach by the Agency of any material term of this Contract, if such breach is not cured within sixty (60) days of the Agency's receipt of the Contractor's written notice of breach.

2.6 Reserved.

2.7 Indemnification.

2.7.1 By the Contractor. The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and elected officials, board and commission members, employees, volunteers, and agents (collectively the "Indemnified Parties"), from any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments (including, without limitation, the reasonable value of the time spent by the Attorney General's Office,) and the costs, expenses, and attorneys' fees of other counsel retained by the Indemnified Parties directly or indirectly related to, resulting from, or arising out of this Contract, including but not limited to any claims related to, resulting from, or arising out of:
2.7.1.1 Any breach of this Contract;
2.7.1.2 Any negligent, intentional, or wrongful act or omission of the Contractor or any agent or subcontractor utilized or employed by the Contractor;
2.7.1.3 The Contractor's performance or attempted performance of this Contract, including any agent or subcontractor utilized or employed by the Contractor;
2.7.1.4 Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa;
2.7.1.5 Any claim of misappropriation of a trade secret or infringement or violation of any intellectual property rights, proprietary rights, or personal rights of any third party, including any claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto) infringes, violates, or misappropriates any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other intellectual property right or proprietary right of any third party.

2.8 Insurance.
2.8.1 Insurance Requirements. The Contractor, and any subcontractor, shall maintain in full force and effect, with insurance companies licensed by the State of Iowa, at the Contractor's expense, insurance covering its work during the entire term of this Contract and any extensions or renewals thereof. The Contractor's insurance shall, among other things:
2.8.1.1 Be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor's performance of this Contract regardless of the date the claim is filed or expiration of the policy.

2.8.1.2. Name the State of Iowa and the Agency as additional insureds or loss payees on the policies for all coverages required by this Contract, with the exception of Workers' Compensation, or the Contractor shall obtain an endorsement to the same effect; and

2.8.1.3 Provide a waiver of any subrogation rights that any of its insurance carriers might have against the State on the policies for all coverages required by this Contract, with the exception of Workers' Compensation.

The requirements set forth in this section shall be indicated on the certificates of insurance coverage supplied to the Agency.

2.8.2 Types and Amounts of Insurance Required. Unless otherwise requested by the Agency in writing, the Contractor shall cause to be issued insurance coverages insuring the Contractor and/or subcontractors against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability in the amount specified in the Special Terms for each occurrence. In addition, the Contractor shall ensure it has any necessary workers' compensation and employer liability insurance as required by Iowa law.

2.8.3 Certificates of Coverage. The Contractor shall submit certificates of the insurance, which indicate coverage and notice provisions as required by this Contract, to the Agency upon execution of this Contract. The Contractor shall maintain all insurance policies required by this Contract in full force and effect during the entire term of this Contract and any extensions or renewals thereof, and shall not permit such policies to be canceled or amended except with the advance written approval of the Agency. The insurer shall state in the certificate that no cancellation of the insurance will be made without at least a thirty (30) day prior written notice to the Agency. The certificates shall be subject to approval by the Agency. Approval of the insurance certificates by the Agency shall not relieve the Contractor of any obligation under this Contract**.**

***2.9 Ownership and Security of Agency Information*.**

2.9.1 Ownership and Disposition of Agency Information. Any information either supplied by the Agency to the Contractor, or collected by the Contractor on the Agency's behalf in the course of the performance of this Contract, shall be considered the property of the Agency ("Agency Information"). The Contractor will not use the Agency Information for any purpose other than providing services under the Contract, nor will any part of the information and records be disclosed, sold, assigned, leased, or otherwise provided to third parties or commercially exploited by or on behalf of the Contractor. The Agency shall own all Agency Information that may reside within the Contractor's hosting environment and/or equipment/media.

2.9.2 Foreign Hosting and Storage Prohibited. Agency Information shall be hosted and/or stored within the United States only.

2.9.3 Access to Agency Information that is Confidential Information. The Contractor's employees, agents, and subcontractors may have access to Agency Information that is Confidential Information to the extent necessary to carry out responsibilities under the Contract. Access to such Confidential Information shall comply with both the State's and the Agency's policies and procedures.

2.9.4 No Use or Disclosure of Confidential Information. Confidential Information collected, maintained, or used in the course of performance of the Contract shall only be used or disclosed by the Contractor as expressly authorized by law and only with the prior written consent of the Agency, either during the period of the Contract or thereafter. The Contractor shall immediately report to the Agency any unauthorized use or disclosure of Confidential Information. The Contractor may be held civilly or criminally liable for improper use or disclosure of Confidential Information.

2.9.5 Contractor Breach Notification Obligations. The Contractor agrees to comply with all applicable laws that require the notification of individuals in the event of unauthorized use or disclosure of Confidential Information or other event(s) requiring notification in accordance with applicable law. In the event of a breach of the Contractor's security obligations or other event requiring notification under applicable law, the Contractor agrees to follow Agency directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws, and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach.

2.9.6 Compliance of Contractor Personnel. The Contractor and the Contractor's personnel shall comply with the Agency's and the State's security and personnel policies, procedures, and rules,

including any procedure which the Agency's personnel, contractors, and consultants are normally asked to follow. The Contractor agrees to cooperate fully and to provide any assistance necessary to the Agency in the investigation of any security breaches that may involve the Contractor or the Contractor's personnel. All services shall be performed in accordance with State Information Technology security standards and policies as well as Agency security protocols and procedures. By way of example only, see Iowa Code 8A.206, http://secureonline.iowa.gov/links/index.html, and http://das.ite.iowa.gov/standards/index.html.

2.9.7 Subpoena. In the event that a subpoena or other legal process is served upon the Contractor for records containing Confidential Information, the Contractor shall promptly notify the Agency and cooperate with the Agency in any lawful effort to protect the Confidential Information.

2.9.8 Return and/or Destruction of Information. Upon expiration or termination of the Contract for any reason, the Contractor agrees to comply with all Agency directives regarding the return or destruction of all Agency Information and any derivative work. Delivery of returned Agency Information must be through a secured electronic transmission or by parcel service that utilizes tracking numbers. Such information must be provided in a format useable by the Agency. Following the Agency's verified receipt of the Agency Information and any derivative work, the Contractor agrees to physically and/or electronically destroy or erase all residual Agency Information regardless of format from the entire Contractor's technology resources and any other storage media. This includes, but is not limited to, all production copies, test copies, backup copies and /or printed copies of information created on any other servers or media and at all other Contractor sites. Any permitted destruction of Agency Information must occur in such a manner as to render the information incapable of being reconstructed or recovered. The Contractor will provide a record of information destruction to the Agency for inspection and records retention no later than thirty (30) days after destruction.

2.9.9 Contractor's Inability to Return and/or Destroy Information. If for any reason the Agency Information cannot be returned and/or destroyed upon expiration or termination of the Contract, the Contractor agrees to notify the Agency with an explanation as to the conditions which make return and/or destruction not possible or feasible. Upon mutual agreement by both parties that the return and/or destruction of the information is not possible or feasible, the Contractor shall make the Agency Information inaccessible. The Contractor shall not use or disclose such retained Agency Information for any purposes other than those expressly permitted by the Agency. The Contractor shall provide to the Agency a detailed description as to the procedures and methods used to make the Agency Information inaccessible no later than thirty (30) days after making the information inaccessible. If the Agency provides written permission for the Contractor to retain the Agency Information in the Contractor's information systems, the Contractor will extend the protections of this Contract to such information and limit any further uses or disclosures of such information.

2.9.10 Contractors that are Business Associates. If the Contractor is the Agency's Business Associate, and there is a conflict between the Business Associate Agreement and this Section 2.9, the provisions in the Business Associate Agreement shall control.

2.10 Intellectual Property.

2.10.1 Ownership and Assignment of Other Deliverables. The Contractor agrees that the State and the Agency shall become the sole and exclusive owners of all Deliverables. The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor's employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any

purpose, without the prior written consent of the Agency and the payment of such royalties or other compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all Deliverables not previously delivered to the Agency, and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors, or affiliates, without the prior written consent of the Agency.

2.10.2 Waiver. To the extent any of the Contractor's rights in any Deliverables are not subject to assignment or transfer hereunder, including any moral rights and any rights of attribution and of integrity, the Contractor hereby irrevocably and unconditionally waives all such rights and enforcement thereof and agrees not to challenge the State's rights in and to the Deliverables.

2.10.3 Further Assurances. At the Agency's request, the Contractor will execute and deliver such instruments and take such other action as may be requested by the Agency to establish, perfect, or protect the State's rights in and to the Deliverables and to carry out the assignments, transfers and conveyances set forth in Section 2.10, *Intellectual Property*.

2.10.4 Publications. Prior to completion of all services required by this Contract, the Contractor shall not publish in any format any final or interim report, document, form, or other material developed as a result of this Contract without the express written consent of the Agency. Upon completion of all services required by this Contract, the Contractor may publish or use materials developed as a result of this Contract, subject to confidentiality restrictions, and only after the Agency has had an opportunity to review and comment upon the publication. Any such publication shall contain a statement that the work was done pursuant to a contract with the Agency and that it does not necessarily reflect the opinions, findings, and conclusions of the Agency.

2.11 Warranties.

2.11.1 Construction of Warranties Expressed in this Contract with Warranties Implied by Law. Warranties made by the Contractor in this Contract, whether: (1) this Contract specifically denominates the Contractor's promise as a warranty; or (2) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of samples to the Agency, shall not be construed as limiting or negating any warranty provided by law, including without limitation, warranties that arise through the course of dealing or usage of trade. The warranties expressed in this Contract are intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. With the exception of Subsection 2.11.3, the provisions of this section apply during the Warranty Period as defined in the Contract Declarations and Execution Section.

2.11.2 Contractor represents and warrants that:

2.11.2.1 All Deliverables shall be wholly original with and prepared solely by the Contractor; or it owns, possesses, holds, and has received or secured all rights, permits, permissions, licenses, and authority necessary to provide the Deliverables to the Agency hereunder and to assign, grant and convey the rights, benefits, licenses, and other rights assigned, granted, or conveyed to the Agency hereunder or under any license agreement related hereto without violating any rights of any third party;

2.11.2.2 The Contractor has not previously and will not grant any rights in any Deliverables to any third party that are inconsistent with the rights granted to the Agency herein; and

2.11.2.3 The Agency shall peacefully and quietly have, hold, possess, use, and enjoy the Deliverables without suit, disruption, or interruption.

2.11.3 The Contractor represents and warrants that:

2.11.3.1 The Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables); and

2.11.3.2 The Agency's use of, and exercise of any rights with respect to, the Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual property right, proprietary right or personal right of any third party. The Contractor further represents and warrants there is no pending or threatened claim, litigation, or action that is based on a claim of infringement or violation of an intellectual property right, proprietary right or personal right or misappropriation of a trade secret related to the Deliverables. The Contractor shall inform the Agency in writing immediately upon

becoming aware of any actual, potential, or threatened claim of or cause of action for infringement or violation or an intellectual property right, proprietary right, or personal right or misappropriation of a trade secret. If such a claim or cause of action arises or is likely to arise, then the Contractor shall, at the Agency's request and at the Contractor's sole expense:

- Procure for the Agency the right or license to continue to use the Deliverable at issue;
- Replace such Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation;
- Modify or replace the affected portion of the Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation; or
- Accept the return of the Deliverable at issue and refund to the Agency all fees, charges, and any other amounts paid by the Agency with respect to such Deliverable. In addition, the Contractor agrees to indemnify, defend, protect, and hold harmless the State and its officers, directors, employees, officials, and agents as provided in the Indemnification Section of this Contract, including for any breach of the representations and warranties made by the Contractor in this section.

The warranty provided in this Section 2.11.3 shall be perpetual, shall not be subject to the contractual Warranty Period, and shall survive termination of this Contract. The foregoing remedies provided in this subsection shall be in addition to and not exclusive of other remedies available to the Agency and shall survive termination of this Contract.

2.11.4 The Contractor represents and warrants that the Deliverables shall:

2.11.4.1 Be free from material Deficiencies; and

2.11.4.2 Meet, conform to, and operate in accordance with all Specifications and in accordance with this Contract during the Warranty Period, as defined in the Contract Declarations and Execution Section. During the Warranty Period the Contractor shall, at its expense, repair, correct or replace any Deliverable that contains or experiences material Deficiencies or fails to meet, conform to or operate in accordance with Specifications within five (5) Business Days of receiving notice of such Deficiencies or failures from the Agency or within such other period as the Agency specifies in the notice. In the event the Contractor is unable to repair, correct, or replace such Deliverable to the Agency's satisfaction, the Contractor shall refund the fees or other amounts paid for the Deliverables and for any services related thereto. The foregoing shall not constitute an exclusive remedy under this Contract, and the Agency shall be entitled to pursue any other available contractual, legal, or equitable remedies. The Contractor shall be available at all reasonable times to assist the Agency with questions, problems, and concerns about the Deliverables, to inform the Agency promptly of any known Deficiencies in any Deliverables, repair and correct any Deliverables not performing in accordance with the warranties contained in this Contract, notwithstanding that such Deliverables may have been accepted by the Agency, and provide the Agency with all necessary materials with respect to such repaired or corrected Deliverable.

2.11.5 The Contractor represents, warrants and covenants that all services to be performed under this Contract shall be performed in a professional, competent, diligent, and workmanlike manner by knowledgeable, trained, and qualified personnel, all in accordance with the terms and Specifications of this Contract and the standards of performance considered generally acceptable in the industry for similar tasks and projects. In the absence of a Specification for the performance of any portion of this Contract, the parties agree that the applicable Specification shall be the generally accepted industry standard. So long as the Agency notifies the Contractor of any services performed in violation of this standard, the Contractor shall re-perform the services at no cost to the Agency, such that the services are rendered in the above-specified manner, or if the Contractor is unable to perform the services as warranted, the Contractor shall reimburse the Agency any fees or compensation paid to the Contractor for the unsatisfactory services.

2.11.6 The Contractor represents and warrants that the Deliverables will comply with any applicable federal, state, foreign and local laws, rules, regulations, codes, and ordinances in effect during the term of this Contract, including applicable provisions of Section 508 of the Rehabilitation Act of 1973, as amended, and all standards and requirements established by the Architectural and Transportation Barriers Access Board and the Iowa Department of Administrative Services, Information Technology Enterprise.

2.11.7 Obligations Owed to Third Parties. The Contractor represents and warrants that all

obligations owed to third parties with respect to the activities contemplated to be undertaken by the Contractor pursuant to this Contract are or will be fully satisfied by the Contractor so that the Agency will not have any obligations with respect thereto.

2.12 Acceptance of Deliverables.

2.12.1 Acceptance of Written Deliverables. For the purposes of this section, written Deliverables means documents including, but not limited to project plans, planning documents, reports, or instructional materials ("Written Deliverables"). Although the Agency determines what Written Deliverables are subject to formal Acceptance, this section generally does not apply to routine progress or financial reports. Absent more specific Acceptance Criteria in the Special Terms, following delivery of any Written Deliverable pursuant to the Contract, the Agency will notify the Contractor whether or not the Deliverable meets contractual specifications and requirements. Written Deliverables shall not be considered accepted by the Agency, nor does the Agency have an obligation to pay for such Deliverables, unless and until the Agency has notified the Contractor of the Agency's Final Acceptance of the Written Deliverables. In all cases, any statements included in such Written Deliverables that alter or conflict with any contractual requirements shall in no way be considered as changing the contractual requirements unless and until the parties formally amend the Contract.

2.12.2. Reserved. ***(Acceptance of Software Deliverables)***

2.12.3 Notice of Acceptance and Future Deficiencies. The Contractor's receipt of any notice of Acceptance, including Final Acceptance, with respect to any Deliverable shall not be construed as a waiver of any of the Agency's rights to enforce the terms of this Contract or require performance in the event the Contractor breaches this Contract or any Deficiency is later discovered with respect to such Deliverable.

2.13 Contract Administration.

2.13.1 Independent Contractor. The status of the Contractor shall be that of an independent contractor. The Contractor, its employees, agents, and any subcontractors performing under this Contract are not employees or agents of the State or any agency, division, or department of the State simply by virtue of work performed pursuant to this Contract. Neither the Contractor nor its employees shall be considered employees of the Agency or the State for federal or state tax purposes simply by virtue of work performed pursuant to this Contract. The Agency will not withhold taxes on behalf of the Contractor (unless required by law).

2.13.2 Incorporation of documents (Reserved).

2.13.3 Intent of Reference to Bid Documents. (Reserved).

2.13.4 Compliance with the Law. The Contractor, its employees, agents, and subcontractors shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations, and orders when providing Deliverables pursuant to this Contract, including without limitation, all laws that pertain to the prevention of discrimination in employment and in the provision of services. For employment, this would include equal employment opportunity and affirmative action, and the use of targeted small businesses as subcontractors or suppliers. The Contractor may be required to provide a copy of its affirmative action plan, containing goals and time specifications, and non-discrimination and accessibility plans and policies regarding services to clients. Failure to comply with this provision may cause this contract to be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for future state contracts or be subject to other sanctions as provided by law or rule. The Contractor, its employees, agents, and subcontractors shall also comply with all federal, state, and local laws regarding business permits and licenses that may be required to carry out the work performed under this Contract. The Contractor may be required to submit its affirmative action plan to the Iowa Department of Management to comply with the requirements of 541 Iowa Administrative Code chapter 4. If all or a portion of the funding used to pay for the Deliverables is being provided through a grant from the Federal Government, the Contractor acknowledges and agrees that pursuant to applicable federal laws, regulations, circulars, and bulletins, the awarding agency of the Federal Government reserves certain rights including, without limitation, a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes, the Deliverables developed under this Contract and the copyright in and to such Deliverables.

2.13.5 Procurement. The Contractor shall use procurement procedures that comply with all

applicable federal, state, and local laws and regulations.

2.13.6 Non-Exclusive Rights. This Contract is not exclusive. The Agency reserves the right to select other contractors to provide Deliverables similar or identical to those described in the Scope of Work during the term of this Contract.

2.13.7 Amendments. This Contract may only be amended by mutual written consent of the parties, with the exception of (1) the Contract end date, which may be extended under the Agency's sole discretion, and (2) the Business Associate Agreement, which may be modified or replaced on notice pursuant to Section 1.5, *Business Associate Agreement.* Amendments shall be executed on a form approved by the Agency that expressly states the intent of the parties to amend this Contract. This Contract shall not be amended in any way by use of terms and conditions in an Invoice or other ancillary transactional document. To the extent that language in a transactional document conflicts with the terms of this Contract, the terms of this Contract shall control.

2.13.8 No Third Party Beneficiaries. There are no third party beneficiaries to this Contract. This Contract is intended only to benefit the State and the Contractor.

2.13.9 Use of Third Parties. The Agency acknowledges that the Contractor may contract with third parties for the performance of any of the Contractor's obligations under this Contract. The Contractor shall notify the Agency in writing of all subcontracts relating to Deliverables to be provided under this Contract prior to the time the subcontract(s) become effective. The Agency reserves the right to review and approve all subcontracts. The Contractor may enter into these contracts to complete the project provided that the Contractor remains responsible for all Deliverables provided under this Contract. All restrictions, obligations, and responsibilities of the Contractor under this Contract shall also apply to the subcontractors and the Contractor shall include in all of its subcontracts a clause that so states. The Agency shall have the right to request the removal of a subcontractor from the Contract for good cause.

2.13.10 Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Contract without regard to the conflict of law provisions of Iowa law. Any and all litigation commenced in connection with this Contract shall be brought and maintained solely in Polk County District Court for the State of Iowa, Des Moines, Iowa, or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa, wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Agency or the State of Iowa.

2.13.11 Assignment and Delegation. The Contractor may not assign, transfer, or convey in whole or in part this Contract without the prior written consent of the Agency. For the purpose of construing this clause, a transfer of a controlling interest in the Contractor shall be considered an assignment. The Contractor may not delegate any of its obligations or duties under this Contract without the prior written consent of the Agency. The Contractor may not assign, pledge as collateral, grant a security interest in, create a lien against, or otherwise encumber any payments that may or will be made to the Contractor under this Contract.

2.13.12 Integration. This Contract represents the entire Contract between the parties. The parties shall not rely on any representation that may have been made which is not included in this Contract.

2.13.13 No Drafter. No party to this Contract shall be considered the drafter of this Contract for the purpose of any statute, case law, or rule of construction that would or might cause any provision to be construed against the drafter.

2.13.14 Headings or Captions. The paragraph headings or captions used in this Contract are for identification purposes only and do not limit or construe the contents of the paragraphs.

2.13.15 Not a Joint Venture. Nothing in this Contract shall be construed as creating or constituting the relationship of a partnership, joint venture, (or other association of any kind or agent and principal relationship) between the parties hereto. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this Contract.

2.13.16 Joint and Several Liability. If the Contractor is a joint entity, consisting of more than one individual, partnership, corporation, or other business organization, all such entities shall be jointly and severally liable for carrying out the activities and obligations of this Contract, for any default of

activities and obligations, and for any fiscal liabilities.

2.13.17 Supersedes Former Contracts or Agreements. This Contract supersedes all prior contracts or agreements between the Agency and the Contractor for the Deliverables to be provided in connection with this Contract.

2.13.18 Waiver. Except as specifically provided for in a waiver signed by duly authorized representatives of the Agency and the Contractor, failure by either party at any time to require performance by the other party or to claim a breach of any provision of the Contract shall not be construed as affecting any subsequent right to require performance or to claim a breach.

2.13.19 Notice. With the exception of the Business Associate Agreement, as set forth in Section 1.5, *Business Associate Agreement*, any notices required by the Contract shall be given in writing by registered or certified mail, return receipt requested, by receipted hand delivery, by Federal Express, courier or other similar and reliable carrier which shall be addressed to each party's Contract Manager as set forth in the Contract Declarations and Execution Section. From time to time, the parties may change the name and address of a party designated to receive notice. Such change of the designated person shall be in writing to the other party.

Each such notice shall be deemed to have been provided:

- At the time it is actually received in the case of hand delivery;
- Within one (1) day in the case of overnight delivery, courier or services such as Federal Express with guaranteed next-day delivery; or
- Within five (5) days after it is deposited in the U.S. Mail.

2.13.20 Cumulative Rights. The various rights, powers, options, elections, and remedies of any party provided in this Contract, shall be construed as cumulative and not one of them is exclusive of the others or exclusive of any rights, remedies or priorities allowed either party by law, and shall in no way affect or impair the right of any party to pursue any other equitable or legal remedy to which any party may be entitled.

2.13.21 Severability. If any provision of this Contract is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Contract.

2.13.22 Time is of the Essence. Time is of the essence with respect to the Contractor's performance of the terms of this Contract. The Contractor shall ensure that all personnel providing Deliverables to the Agency are responsive to the Agency's requirements and requests in all respects.

2.13.23 Authorization. The Contractor represents and warrants that:

2.13.23.1 It has the right, power, and authority to enter into and perform its obligations under this Contract.

2.13.23.2 It has taken all requisite action (corporate, statutory, or otherwise) to approve execution, delivery, and performance of this Contract and this Contract constitutes a legal, valid, and binding obligation upon itself in accordance with its terms.

2.13.24 Successors in Interest. All the terms, provisions, and conditions of the Contract shall be binding upon and inure to the benefit of the parties hereto and their respective successors, assigns, and legal representatives.

2.13.25 Records Retention and Access.

2.13.25.1 Financial Records. The Contractor shall maintain accurate, current, and complete records of the financial activity of this Contract which sufficiently and properly document and calculate all charges billed to the Agency throughout the term of this Contract and for a period of at least seven (7) years following the date of final payment or completion of any required audit (whichever is later). If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the seven (7) year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular seven (7) year period, whichever is later. The Contractor shall permit the Agency, the Auditor of the State of Iowa or any other authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records, or other records of the Contractor relating to orders, Invoices or payments, or any other Documentation or materials pertaining to this Contract, wherever such records may be located. The Contractor shall not

impose a charge for audit or examination of the Contractor's books and records. Based on the audit findings, the Agency reserves the right to address the Contractor's board or other managing entity regarding performance and expenditures. When state or federal law or the terms of this Contract require compliance with OMB Circular A-87, A-110, or other similar provision addressing proper use of government funds, the Contractor shall comply with these additional records retention and access requirements:

2.13.25.1.1 Records of financial activity shall include records that adequately identify the source and application of funds. When the terms of this Contract require matching funds, cash contributions made by the Contractor and third-party in-kind (property or service) contributions, these funds must be verifiable from the Contractor's records. These records must contain information pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures, income, and third-party reimbursements.

2.13.25.1.2 The Contractor shall maintain accounting records supported by source documentation that may include but are not limited to cancelled checks, paid bills, payroll, time and attendance records, and contract award documents.

2.13.25.1.3 The Contractor, in maintaining project expenditure accounts, records and reports, shall make any necessary adjustments to reflect refunds, credits, underpayments or overpayments, as well as any adjustments resulting from administrative or compliance reviews and audits. Such adjustments shall be set forth in the financial reports filed with the Agency.

2.13.25.1.4 The Contractor shall maintain a sufficient record keeping system to provide the necessary data for the purposes of planning, monitoring, and evaluating its program.

2.13.25.2 The Contractor shall retain all non-medical and medical client records for a period of seven (7) years from the last date of service for each patient; or in the case of a minor patient or client, for a period consistent with that established by Iowa Code § 614.1(9).

2.13.26 Audits. Local governments and non-profit subrecipient entities that expend $500,000 or more in a year in federal awards (from all sources) shall have a single audit conducted for that year in accordance with the provisions of OMB Circular A-133 "Audit of States, Local Governments, and Non-Profit Organizations." A copy of the final audit report shall be submitted to the Agency if either the schedule of findings and questioned costs or the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. If an audit report is not required to be submitted per the criteria above, the subrecipient must provide written notification to the Agency that the audit was conducted in accordance with Government Auditing Standards and that neither the schedule of findings and questioned costs nor the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. See A-133 Section 21 for a discussion of subrecipient versus vendor relationships. The Contractor shall provide the Agency with a copy of any written audit findings or reports, whether in draft or final form, within two (2) Business Days following receipt by the Contractor. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors.

2.13.27 Reimbursement of Audit Costs. If the Auditor of the State of Iowa notifies the Agency of an issue or finding involving the Contractor's noncompliance with laws, rules, regulations, and/or contractual agreements governing the funds distributed under this Contract, the Contractor shall bear the cost of the Auditor's review and any subsequent assistance provided by the Auditor to determine compliance. The Contractor shall reimburse the Agency for any costs the Agency pays to the Auditor for such review or audit.

2.13.28 Staff Qualifications and Background Checks. The Contractor shall be responsible for assuring that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the Contractor, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

The Agency reserves the right to conduct and/or request the disclosure of criminal history and other background investigation of the Contractor, its officers, directors, shareholders, and the Contractor's staff, agents, or subcontractors retained by the Contractor for the performance of Contract services.

2.13.29 Solicitation. The Contractor represents and warrants that no person or selling agency has been

employed or retained to solicit and secure this Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency excepting bona fide employees or selling agents maintained for the purpose of securing business.

2.13.30 Obligations Beyond Contract Term. All obligations of the Agency and the Contractor incurred or existing under this Contract as of the date of expiration or termination will survive the expiration or termination of this Contract. Contract sections that survive include, but are not necessarily limited to, the following: (1) Section 2.4.2, *Erroneous Payments and Credits*; (2) Section 2.5.5, *Limitation of the State's Payment Obligations*; (3) Section 2.5.6, *Contractor's Contract Close-Out Duties*; (4) Section 2.7, *Indemnification*, and all subparts thereof; (5) Section 2.9, *Ownership and Security of Agency Information*, and all subparts thereof; (6) Section 2.10, *Intellectual Property*, and all subparts thereof; (7) Section 2.13.10, *Choice of Law and Forum*; (8) Section 2.13.16, *Joint and Several Liability*; (9) Section 2.13.20, *Cumulative Rights*; (10) Section 2.13.24 *Successors In Interest*; (11) Section 2.13.25, *Records Retention and Access*, and all subparts thereof; (12) Section 2.13.26, *Audits*; (13) Section 2.13.27, *Reimbursement of Audit Costs*; (14) Section 2.13.35, *Repayment Obligation*; and (15) Section 2.13.39, *Use of Name or Intellectual Property*.

2.13.31 Counterparts. The parties agree that this Contract has been or may be executed in several counterparts, each of which shall be deemed an original and all such counterparts shall together constitute one and the same instrument.

2.13.32 Delays or Potential Delays of Performance. Whenever the Contractor encounters any difficulty which is delaying or threatens to delay the timely performance of this Contract, including but not limited to potential labor disputes, the Contractor shall immediately give notice thereof in writing to the Agency with all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the Agency or the State of any rights or remedies to which either is entitled by law or pursuant to provisions of this Contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay. Furthermore, the Contractor will not be excused from failure to perform that is due to a Force Majeure unless and until the Contractor provides notice pursuant to this provision.

2.13.33 Delays or Impossibility of Performance Based on a Force Majeure. Neither party shall be in default under the Contract if performance is prevented, delayed, or made impossible to the extent that such prevention, delay, or impossibility is caused by a Force Majeure. If a Force Majeure delays or prevents the Contractor's performance, the Contractor shall immediately use its best efforts to directly provide alternate, and to the extent possible, comparable performance. The party seeking to exercise this provision shall immediately notify the other party of the occurrence and reason for the delay. The parties shall make every effort to minimize the time of nonperformance and the scope of work not being performed due to the unforeseen events. Dates by which performance obligations are scheduled to be met will be extended only for a period of time equal to the time lost due to any delay so caused.

2.13.34 Right to Address the Board of Directors or Other Managing Entity. The Agency reserves the right to address the Contractor's board of directors or other managing entity of the Contractor regarding performance, expenditures, and any other issue the Agency deems appropriate.

2.13.35 Repayment Obligation. In the event that any State and/or federal funds are deferred and/or disallowed as a result of any audits or expended in violation of the laws applicable to the expenditure of such funds, the Contractor shall be liable to the Agency for the full amount of any claim disallowed and for all related penalties incurred. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors.

2.13.36 Reporting Requirements. If this Contract permits other State agencies and political subdivisions to make purchases off of the Contract, the Contractor shall keep a record of the purchases made pursuant to the Contract and shall submit a report to the Agency on a quarterly basis. The report shall identify all of the State agencies and political subdivisions making purchases off of this Contract and the quantities purchased pursuant to the Contract during the reporting period.

2.13.37 Immunity from Liability. Every person who is a party to the Contract is hereby notified and agrees that the State, the Agency, and all of their employees, agents, successors, and assigns are immune from liability and suit for or from the

Contractor's and/or subcontractors' activities involving third parties and arising from the Contract.

2.13.38 Public Records. The laws of the State require procurement and contract records to be made public unless otherwise provided by law.

2.13.39 Use of Name or Intellectual Property. The Contractor agrees it will not use the Agency and/or State's name or any of their intellectual property, including but not limited to, any State, state agency, board or commission trademarks or logos in any manner, including commercial advertising or as a business reference, without the expressed prior written consent of the Agency and/or the State.

2.13.40 Taxes. The State is exempt from Federal excise taxes, and no payment will be made for any taxes levied on the Contractor's employees' wages. The State is exempt from State and local sales and use taxes on the Deliverables.

2.13.41 No Minimums Guaranteed. The Contract does not guarantee any minimum level of purchases or any minimum amount of compensation.

2.14 Contract Certifications. The Contractor will fully comply with obligations herein. If any conditions within these certifications change, the Contractor will provide written notice to the Agency within twenty-four (24) hours from the date of discovery.

2.14.1 Certification of Compliance with Pro-Children Act of 1994. The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the Deliverables are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where Women, Infants, and Children (WIC) coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day.

2.14.2 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transactions

By signing this Contract, the Contractor is providing the certification set out below:

2.14.2.1 The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2.14.2.2 The Contractor shall provide immediate written notice to the Agency if at any time the Contractor learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

2.14.2.3 The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. Contact the Agency for assistance in obtaining a copy of those regulations.

2.14.2.4 The Contractor agrees by signing this Contract that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Agency or agency with which this transaction originated.

2.14.2.5 The Contractor further agrees by signing this Contract that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transaction," without modification, in all

lower tier covered transactions and in all solicitations for lower tier covered transactions.

2.14.2.6 A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

2.14.2.7 Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

2.14.2.8 Except for transactions authorized under Section 2.14.2.4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2.14.2.9 The Contractor certifies, by signing this Contract, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

Where the Contractor is unable to certify to any of the statements in this certification, such Contractor shall attach an explanation to this Contract.

2.14.3 Certification Regarding Lobbying. The Contractor certifies, to the best of his or her knowledge and belief, that:

2.14.3.1 No federal appropriated funds have been paid or will be paid on behalf of the sub-grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement.

2.14.3.2 If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

2.14.3.3 The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

2.14.4 Certification Regarding Drug Free Workplace

2.14.4.1 Requirements for Contractors Who are Not Individuals. If the Contractor is not an individual, the Contractor agrees to provide a drug-free workplace by:

2.14.4.1.1 Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

2.14.4.1.2 Establishing a drug-free awareness program to inform employees about:

- The dangers of drug abuse in the workplace;
- The Contractor's policy of maintaining a drug- free workplace;
- Any available drug counseling, rehabilitation, and employee assistance programs; and

- The penalties that may be imposed upon employees for drug abuse violations;

2.14.4.1.3 Making it a requirement that each employee to be engaged in the performance of such contract be given a copy of the statement required by Subsection 2.14.4.1.1;

2.14.4.1.4 Notifying the employee in the statement required by Subsection 2.14.4.1.1 that as a condition of employment on such contract, the employee will:

- Abide by the terms of the statement; and
- Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

2.14.4.1.5 Notifying the contracting agency within ten (10) days after receiving notice under the second unnumbered bullet of Subsection 2.14.4.1.4 from an employee or otherwise receiving actual notice of such conviction;

2.14.4.1.6 Imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by 41 U.S.C. § 703; and

2.14.4.1.7 Making a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

2.14.4.2 Requirement for Individuals. If the Contractor is an individual, by signing the Contract, the Contractor agrees not to engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Contract.

2.14.4.3 Notification Requirement. The Contractor shall, within thirty (30) days after receiving notice from an employee of a conviction pursuant to 41 U.S.C. § 701(a)(1)(D)(ii) or 41 U.S.C. § 702(a)(1)(D)(ii)**:**

2.14.4.3.1 Take appropriate personnel action against such employee up to and including termination; or

2.14.4.3.2 Require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

2.14.5 Conflict of Interest. The Contractor represents, warrants, and covenants that no relationship exists or will exist during the Contract period between the Contractor and the Agency that is a conflict of interest. No employee, officer, or agent of the Contractor or subcontractor shall participate in the selection or in the award or administration of a subcontract if a conflict of interest, real or apparent, exists. The provisions of Iowa Code chapter 68B shall apply to this Contract. If a conflict of interest is proven to the Agency, the Agency may terminate this Contract, and the Contractor shall be liable for any excess costs to the Agency as a result of the conflict of interest. The Contractor shall establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by the desire for private gain for themselves or others with whom they have family, business, or other ties. The Contractor shall report any potential, real, or apparent conflict of interest to the Agency.

SECTION 3: SPECIAL CONTRACT ATTACHMENTS

The Special Contract Attachments in this section are identified on the Contract Declarations and Execution Section and are a part of the Contract.

3.1 Benefits

Special Attachment 3.1: Benefit Tiers			
	CORE	**ENHANCED**	**ENHANCED PLUS**
Member Action to Earn Benefits	Member is enrolled in the Iowa Wellness Plan	The Member has actively taken steps to maintain oral health by returning for a periodic exam within 6-12 months of the first visit.* *The initial follow-up visits is either the first follow-up visit upon enrolling into the Iowa Wellness Plan receiving the first exam OR the first follow-up visit after starting over due to non-compliance	The Member has taken steps to actively manage their oral health by returning for a second periodic exam within 6-12 months of the first periodic exam.* *The first periodic exam refers to when the Member became eligible for the Enhanced benefit tier.

Benefits Available	**Oral Health Clinical Risk Assessment** (1 per year)
	
	Diagnostic and Preventive
	Exams and Education
	• Periodic exams (max of 2 per 12 months, 6 months apart)
	• Comprehensive exam (max of 1 every 3 years, per dentist)
	• Perio comprehensive exam (max 1 per 12 months)
	• Consultation (max 1 per 12 months)
	• Oral Hygiene Education (max of 1 every 3 years)
	Cleanings (max of 2 per 12 months, at least 6 months apart, or 4 per 12 months for Perio cleaning for first 24 months post-surgery and therapy)
	• Cleanings
	• Perio cleanings
	X-Rays
	• Bitewing, Occlusal X-Rays (max of 1 per 12 months)
	• Full mouth/panoramic (1 per every 5 years)
	Other
	• Fluoride (max 1 per 12 months)
	
	Emergency Services – Primarily to relieve significant pain or to relieve acute infections (unlimited subject to specific criteria)
	• Problem focused exams
	• Extractions/oral surgery
	• Surgical incision and drain
		All CORE benefits plus the following:
		• Restorations and other restorative services
		• Root canals, apexification, apicoectomy, and other endodontic services
		• Non-surgical gum treatment
		• Denture adjustments, repairs, relines (limit 2 per 12 months)
		• Non-surgical and surgical extractions and other oral surgery services
		• Designated adjunctive services
			All ENHANCED benefits plus the following:
			• Crowns/inlays – for anterior permanent teeth with extensive coronal destruction/broken cusp and posterior teeth with root canal therapy and cracked tooth syndrome
			• Tooth replacements
			  • Dentures (partial) – for replacing anterior teeth and posterior teeth when there are fewer than eight teeth in occlusion or when required to balance the occlusion
			  • Dentures (complete) for edentulous
			  • Bridges (only covered for designated clinical conditions in which a partial denture is contraindicated
			• Gum surgery
			
			The above Enhanced Plus additional services are subject to prior authorization

	• Anesthesia, • Palliative treatment • Periapical, panoramic X-rays • Pupal therapy **Stabilization** – Procedures that allow a Member to maintain basic human functions,(e.g. eating and speech, or preventing a condition from deteriorating in an imminent timeframe to a more serious situation) subject to specific criteria. • Restorations for large cavities impinging on the pulp • Scaling and root planing • Stainless steel (posterior)/resin crowns (anterior) for fractured teeth (once per tooth per lifetime) • Full mouth debridement (max of 1 per lifetime) • Extractions-related to delivery of dentures • Denture adjustments and repairs (2 adjustments/repairs per year) • Complete dentures for edentulous and partial for replacement of anterior teeth		
Member Action to Maintain Earned Benefits	Member remains in enrolled in the Iowa Wellness Plan	Member must return for one periodic exam every 6-12 months of previous periodic exam Note: If the Member fails to comply with requirements, they will no longer have access to Enhanced services; the Member will only have access to Core Services and must start over to earn additional benefits.	The Member must return for one periodic exam every 6-12 months from previous periodic exam. Note: If the Member fails to comply with requirements, they will no longer have access to Enhanced services; the Member will only have access to Core Services and must start over to earn additional benefits.

3.2 Complaint/Appeal Reporting Form

COMPLAINT/APPEAL REPORTING FORM

(Use to record each complaint/appeal)

Date		
Enrollee ID		
Last name, First name		
City, zip code		
Gender **M-** male **F-** female		
A- Appeal **C**- Complaint		
Date of Appeal or Complaint		
Problem as described by the Enrollee:		
PROBLEM FINAL RESOLUTION (date/how)	Enter date (mm/dd/yy)	Enter: 1- if to Enrollee's satisfaction 2 - if not to Enrollee's satisfaction
Administrative resolution/system error		
Contacting physician/provider in question		
Other		
DENIAL OF PAYMENT (reason)		Enter: 1 - if denial upheld 2 - if denial reversed
System error		
Emergency room utilization		
Did not obtain Prior Authorization for services utilized		
Other		
QUALITY OF CARE		
Quality of care received		
Poor health education		
Poor communication of treatment needs by health providers		
Poor provider/patient relationship		
Other		
ACCESS TO SERVICES		
Could not find a physician to provide care		
Difficulty getting an appointment		
Long office wait times for the scheduled appt.		

Provider too far/travel time too long		
Problems obtaining services outside regular hours		
Denied services thought needed		
Cannot obtain services recommended by the PCP through the program		
Cannot get referral to a specialist thought needed		
Afraid to access emergency care for fear of having to pay for it		
Other		
COMMUNICATION		
Lack of respect since joining the program (culturally specific)		
Lack of respect since joining the program		
Cannot understand how to get services through the program		
Getting services process too complicated		
Difficulties communicating with health care providers (language problem)		
Difficulties communicating with health care providers (general)		
Other		